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THE BRITISH JOURNAL OF DERMATOLOGY.

JANUARY, 1905.

STRIÆ PATELLARES.

By J. L. BUNCH, M.D., D.Sc.

THE following are two cases of striæ patellares:

The first case was that of a boy aged 13½ years, who had had typhoid fever five months previously. The disease had apparently run a fairly normal course, but convalescence had been slow, and the boy was still weak and poorly nourished when I saw him. Above both knees were a number of irregular pinkish striæ (Fig. 1), which, his mother said, had made their appearance during his illness, but had been deeper in colour two months before, and now seemed to be fading. The striæ ran transversely to the long axis of the limb, were irregularly and asymmetrically arranged, and varied in width from a few lines to about an eighth of an inch. At the ends they tapered off somewhat, and were narrower there than in the middle of their length. They were present on both legs and were situated on the extensor surface of the leg opposite the lower end of the femur above the patella. There was no anæsthesia of the skin over the striæ, nor did the patient complain of any pain when I saw him, but in the latter part of his typhoid illness he was said to have suffered considerably from pain in the region of his knees. He had grown about an inch and a quarter since the beginning of his illness. Knee-jerks were present, but sluggish. There was no history of any swelling of the thigh, nor of any contracture, and the patient could move his legs perfectly well all through his illness.

The second case was one of a girl, aged 12 years, who, when seen

this year, had been ill for four months previously with plenrisy and endocarditis. She had wasted very considerably, and her temperature had been high. During the four months of her illness she had been kept lying down, but she could move her legs perfectly well and did not, her nurse said, usually lie with her legs flexed. She was thought to have grown considerably in height during her illness, but the increase in height was difficult of measurement while she was lying in bed. The striæ had made their appearance during her illness, but their advent had not been marked by any pain. They were situated above the patellæ on both legs (Fig. 2); they were pinkish-blue in colour, asymmetrical and irregular in length and distribution. Alteration of sensation over the striæ was not present. Knee-jerks were present.

Striæ patellares are of somewhat rare occurrence, but a certain number of cases have already been reported.

Northrup* describes and figures the striæ which developed above the knees in a lad aged 17 years after an attack of typhoid fever. They were at first reddish, "like wales or welts made by a switch." There were no other similar scars on his limbs or body.

Shepherd† records the case of a boy aged 15 years who, when convalescing from typhoid fever developed above both knees and over both patellæ numerous purplish striæ, the colour of which deepened when the erect position was assumed. All the striæ were perfectly sensitive. On passing the finger over them the sensation of a depression was communicated to it, the skin feeling dry and thin. Some new striæ developed and their colour was first reddish, but afterwards became a purplish blue. Before the boy left the hospital the oldest striæ were already of a decidedly lighter colour.

Fischer‡ has recently recorded a case in a child aged 13 years where striæ developed above the knee after typhoid fever.

Northrup quotes Norris' description of old scars in a patient who had typhoid when 13. The scars remained reddish for five or six years after recovery from the fever. They appeared during convalescence, and there were as many as fifteen to twenty slightly curved scars, arranged in more or less parallel rows, and running at right angles to the length of the femora, situated over or just above the knees.

* *Trans. Ass. Amer. Phys.*, 1903.

† *Journ. Cut. and Gen.-Ur. Dis.*, 1891, p. 59.

‡ *Münch. med. Wochenschr.*, 1904, p. 482.



FIG. 1.



FIG. 2.

TO ILLUSTRATE DR. BUNCH'S CASES OF STRIAE PATELLARES.

Köbner * reports two cases of young girls who developed patellar striæ after typhoid fever. The first, a girl aged 13 years, had about eight striæ, bluish-red in colour, on the extensor surface of each thigh, ceasing just above the patella, with areas of normal skin between them. They varied in length, but the skin was quite smooth over them and there was no loss of sensation. The patient when seen twenty-three years afterwards was found to have broad white scars in the same positions, over which the skin was finely crenated. The second patient was a girl of 14 who developed similar scars after typhoid fever.

Sir Dyce Duckworth † records unilateral striæ on the thigh in a patient aged 15 years after typhoid fever. In this case there was accompanying hyperæsthesia of the skin in the distribution of the external and middle cutaneous nerves.

Gubler, Bouchard, and others have also observed such striæ during convalescence from typhoid fever, and various explanations have been put forward to account for their occurrence. It has been stated that they are directly produced by the presence of the specific bacillus—the *Bacillus typhosus*—in the organism, and that its toxins act on the trophic nerves of the skin. In support of a tropho-neurotic origin it has been pointed out that Nonne ‡ has shown the presence of neuritis affecting only the crural nerve in typhoid fever, and leading to loss of knee-jerk.

In typhoid fever, also, it has been urged that frequently unusual growth takes place in the long bones, especially the femora, owing either to absence of pressure upon the epiphysis during prolonged rest in bed, or to a juxta-epiphysial osteitis. Even in children who were not suffering from typhoid fever, but were growing rapidly, Bonilly § has described the occurrence of temporary periods of fever, accompanied by tender points at the level of the tibio-femoral epiphyses. Measurement of the limb before and after the attack may show an increase in length varying from 1 to $1\frac{1}{2}$ centimetre. Bonilly ascribed this change to a mild juxta-epiphysial osteitis, and had met with cases in which the fever alone occurred, the pains being

* *Manch. med. Wochenschr.*, 1904, p. 928.

† *British Journal of Dermatology*, 1893, p. 357.

‡ *Eppendorfer Festschrift*, 1889.

§ *Rev. de Méd. et de Chir.*, 1879.

very slight or absent. Lannelongue has also described similar cases with swelling of the apophysis ("ostéite apophysaire"). Such an over-activity of epiphysial bone formation might perhaps be due to the action of inflammatory products brought by the blood-stream, generated by the organisms which have produced a specific disease.

The striæ have further been ascribed to simple stretching of the skin by reason of the excessive growth in length of the long bones with disproportionate growth of skin, and to the peculiar position with its legs drawn up in which a child often lies in typhoid fever. Where such excessive tension occurs, Kaposi* showed that ruptures occur in the subcutaneous tissue and deeper layers of the cutis, accompanied by coincident rupture of blood-vessels, the resulting lesion being, therefore, pink or red in colour. The colour afterwards changes in many cases to a brownish tint and may finally disappear. Küstner has pointed out that even old lesions when examined by a certain light and at a certain angle still show a reddish tint of their floor. Balzer, however, denies the occurrence of vascular rupture or hæmorrhage, and states that when this occurs it is due to some coincident malady.

Patellar striæ are not, however, absolutely peculiar to typhoid fever, although even in it they are rare. During an extensive epidemic in Paris, Perroud and Anboyer on examining a very large number of patients failed to find a single case, and Sieveeking on examination of several thousand patients only found one case. Similar striæ have nevertheless been reported by Tussat and Brissand in plithisical patients; and by Chevallereau in a patient, aged 20 years, who was laid up for eight months with colitis, but who did not have typhoid. In other positions than above the patella linear striæ have, of course, been described frequently. Lineæ gravidarum are common, striæ have been seen above the olecranon and malleoli, and Balzer has seen them at the base of the vertebral column. Kirstein and Gilbert† have described their occurrence on the trunk in lung cases; Ohmann-Dumesnil‡ on the arm, accompanied by wasting of the limb and slight hyperæsthesia, in a girl aged 7 years; while ascites, obesity, or other causes of distension may cause linear striæ. In the museum of

* Hebra and Kaposi, *Diseases of the Skin*, 1874, p. 264.

† *Arch. Gén. de Méd.*, 1887, p. 685.

‡ *Brit. Journ. Derm.*, 1890, p. 246.

the Hôpital Saint-Louis are models of several cases of linear striæ, one of which, number 1275, shows linear striæ as a result of typhoid fever, but on the flank. Another, number 1504, shows atrophic lines round both breasts, but without any special increase in size of the breasts, and without the existence of pregnancy. Linear striæ can, undoubtedly, occur in adults where there can be no question that unusual growth of a long bone has caused over-tension of the skin. Forced extension of the skin in jumping or other violent exercise seems able to cause ruptures in the subcutaneous tissues and deeper layers of the cutis attended in rare cases with inflammatory swelling in predisposed individuals, and Podratzky observed an instance of this in a soldier. The colour of the striæ is at first usually pink or rose, and it is only after the lapse of an appreciable time that they become white. There is, as a rule, no anæsthesia over the lesions at any period of their existence, but Wilson has described cases of white anæsthetic streaks developing over the course of nerves, possibly of a tropho-neurotic origin. Nonne's demonstration of the occurrence of anterior crural neuritis in typhoid seems to be supported by Remlinger's * report of absence of knee-jerks in 29 per cent. of soldiers after typhoid, with diminution of knee-jerks in 17 per cent. Remak describes polyneuritis as being rare in typhoid, mono-neuritic affections more common. But it has been asserted that these striæ may result from disease of the central nervous system, and Cantani has recorded a case of a young man with disease of the spinal cord, who had never been obese, but who developed these striæ. Moreover, Féré and Quermonde have described the same in certain nerve cases, and Arnould in epileptics.

Histological Examination.—I have not had an opportunity of making a biopsy of a quite recent lesion, but sections of a portion excised from one which was losing its pigmentation showed chiefly an alteration of the elastic fibres, and to a less extent of the white fibrous tissue. A few fibres of the latter were found to have undergone rupture, and this variety of connective tissue showed a slight general thinning over the site of the lesion. Over the same area the elastic network showed a much more definite alteration from the normal, the interlacing of the elastic fibres being much less marked than normal, owing to the new parallel arrangement of the fibres. This parallel

* *Rev. de Méd.*, 1901, p. 46.

arrangement has been brought about at the expense of the crossing transverse elastic fibres, which had ruptured and retracted to the edge of the lesion. In the centre of the lesion, therefore, the total number of elastic fibres was less than that found in healthy skin, and these were running more or less parallel to one another.

At the edge of the lesion were the broken ends of the missing elastic fibres which had retracted, and the elastic tissue appeared here more dense than normal. In the pars reticularis of the corium these changes were best marked, and the more slender fibrils of the elastic network seemed to have suffered most. The branching fibrils which surround the sweat-glands and hair-follicles tend, no doubt, when dragged upon to cause a deflection of these glands and follicles, and Troisier and Menetrier* have also described an alteration in the course of the blood-vessels due to the same cause, but my sections did not show clearly any such change. In addition to these changes in the corium there was slight flattening of the prickle-cell layer, but the lesion was essentially one involving the corium more than the papillary layer and prickle-cells. There was some slight round-celled infiltration round the blood-vessels. The method of staining which gave, perhaps, the best result for the elastic fibres was Weigert's resorcin-fuchsin method, where the elastic fibres are stained a dark bluish purple; and Unna's acid fuchsin method, where the elastic fibres are stained a purplish violet, also gave good results. In the latter method it is necessary to decolourise in dilute acetic acid, after passing the section through nitric acid solution (1 in 4).

The histological appearances detailed above seem to lead to the conclusion that rupture of the elastic fibres of the corium had taken place, due probably to stretching or tension rather than to inflammation. Similar appearances have been described in sections of *striae atrophicæ* in other positions. Neither case gave any ground for the assumption that the tension had been a sudden one; but in both cases there had been an increase in the child's height, and in the case of the boy there was a history of pains about the knees which might correspond to an "ostéite apophysaire," and a consequent over-activity of the epiphysial bone formation, due, possibly, to the action of inflammatory products brought by the blood-stream. The absence of loss of knee-jerks did not warrant the assumption of

* *Arch. de Méd. Expér.*, 1889, p. 134.

anterior crural neuritis, nor was it possible to demonstrate the involvement of any trophic nerves.

TREATMENT OF SYPHILIS ON THE CONTINENT.

By MAJOR C. E. POLLOCK, R.A.M.C.

HAVING recently had the opportunity of visiting some of the leading dermatological clinics on the Continent, and of observing the methods of treatment there employed, I have considered that the following notes on the treatment of syphilis might prove of interest in showing the general plan and method of treatment of this disease in different countries. In these notes I would especially call attention to the following points:

1. The diagnosis of syphilis in its earliest stages.
2. The stage of the disease at which mercurial treatment is begun.
3. The general plan of treatment.
4. The methods of treatment employed.

My reasons for selecting the above headings are briefly that among syphilologists there exists considerable diversity of opinion as regards the best course to pursue, and it seemed possible that your readers might care to have a rough outline of the Continental treatment for purposes of comparison with English methods.

PARIS.—*Diagnosis*.—As a general rule the character of the sore alone was relied on in making a diagnosis, some attention being paid to the state of the inguinal lymphatic glands, but the decision not being influenced to any great extent by them.

Treatment.—The great majority of out-patients were treated by means of pills, and almost everywhere the green iodide of mercury was the preparation employed. Professor Gaucher still preferred Ricord's sublimate pills, while Brocq prescribed sublimate in solution. A few of the out-patients were treated by means of injections, but this method did not seem to be popular.

Patients in hospital were mostly treated by means of injections, a great variety of preparations being made use of, but on the whole there seemed to be a distinct preference for the soluble salts, as being less dangerous and equally effective. Queyrat was trying a large

number of organic compounds of mercury in the hope of finding one which, while easily soluble and effective, would be free from pain or liability to cause mercurial poisoning.

At the Maison Lazare, Jullien was using calomel injections largely, and the patients did not complain of excessive pain, while the therapeutic effect was excellent.

The plan of treatment generally followed was that known as Fournier's "chronic intermittent" one. Gaucher's leaflet for out-patients suffering from syphilis contains the following directions, and these may be taken as fairly representative of the general practice. ". . . During the first year take the pills for the first two months and afterwards every second month up to the end of the year. During the second year take the pills every second month, but omit doing so for two consecutive months in the middle of the year. During the third year take the pills for one month in every three. During the fourth year take the pills for one month in each half-year."

One other point worth noticing was that Gaucher laid great stress on the value of natural sulphurous waters in the mercurial treatment of syphilis; he believed that a glass of Uriages water each morning not only greatly assisted the beneficial effect of the mercury, but also that it would almost certainly prevent many of the unpleasant complications, such as diarrhœa, which might accompany the exhibition of the drug.

ITALY.—In addition to visiting several military hospitals I had the opportunity of seeing the civil practice in Rome and Milan.

Diagnosis.—When the sore presented definite syphilitic characters a diagnosis of syphilis was made, but should there be any doubt on the matter the appearance of confirmatory symptoms was awaited.

Methods of treatment.—As far as I was able to judge in civil practice, injection is the method most commonly employed, while the military hospitals make an equal use of inunction. The two preparations most commonly used for injections are the sublimate at Rome, and calomel at Milan. In connection with the latter Bertarelli pointed out that about the fourth day after the injection a certain amount of local swelling took place at the site of injection; this might or might not be painful, but if asepsis had been maintained the induration disappeared by the tenth day. None of the patients under treatment by calomel injections complained of severe pain, and not one out of a large number whom I saw objected to the treatment on

that account, while the medicinal effect was all that could be desired. At these cliniques pills were rarely prescribed; in fact, I think I am right in saying that pills were regarded as a last resort, and not to be used if any other method were available.

Plan of treatment.—The general plan of treatment was to give definite courses of mercury separated by intervals of at least twice or three times as long as the period of treatment. The whole duration of treatment lasted from three to five years, including the gradually increasing intervals.

GERMANY AND AUSTRIA.—To avoid repetition I shall include Austria under Germany. In these countries I had the opportunity of seeing and becoming fairly well acquainted with the practice followed in Vienna and Berlin, while shorter visits were paid to Buda-Pesth, Breslau, Munich, Aachen, and Wiesbaden. From what I saw in these places I think I am justified in summing up the general plan of treatment in Germany under the following headings :

Diagnosis of early syphilis.—As long as a chancre was the only manifestation of syphilis the diagnosis was restricted to “sclerose,” and the treatment was limited to the application of mercurial plaster. In Lang’s clinique it was customary at this stage of the disease to give small doses (15 grains daily) of potassium iodide, not with the idea of curing the disease, but in order to minimise the headaches and other nervous disturbances which so often accompany the appearance of the secondary eruption.

When constitutional symptoms of the disease had appeared, but not before, a diagnosis of syphilis was made and treatment was begun. This practice is not in accordance with the teaching of most English syphilographers, who, as a rule, insist on the early exhibition of mercury as soon as a reasonable suspicion of syphilis exists, believing that by this means we can successfully attack the disease before it obtains a firm hold on the patient, and so prevent the occurrence of later relapses or parasyphilides. As this question is of great importance to the army surgeon, I seized every opportunity of asking these authorities why they adopted this plan of treatment, and, as far as possible, I have grouped the answers given me under the following headings :

1. No one, however experienced he may be, can be absolutely certain, from the character of the sore, that this is the primary

inoculation of syphilis. If treatment is begun at this stage of the disease and no further signs of the disease appear, both patient and surgeon are certain to entertain some lingering doubts as to the correctness of the diagnosis, with the almost inevitable result that thorough treatment to eradicate the disease is not so likely to be enforced: the patient may even insist on contracting marriage against the surgeon's advice, and in any case he runs a serious risk of suffering from one of the late forms of central nervous lesion at some future stage of his life. Again, if, in spite of your treatment, secondary symptoms do appear, what have you gained by beginning the mercury a few weeks earlier?

2. Another point which must be considered is this: A mercurial course, to be of real value, should extend over some years, entailing considerable inconvenience and even risk to the patient. Are we justified in subjecting him to this unless we are absolutely convinced of the necessity for it? Can it be claimed that by beginning mercurial treatment a few weeks earlier we appreciably shorten the total time of treatment? As to the severity of the disease being aggravated by withholding mercury till secondary symptoms have appeared, the Germans do not believe this to be the case and say that there is no evidence to justify such a statement. Some even maintain that mercury has a more powerful anti-syphilitic action during the secondary stage of the disease, and that consequently a smaller dose of the poison mercury will destroy the poison syphilis, thus effecting a cure with a much smaller quantity of the deleterious substance—to wit, mercury.

Plan of treatment.—The plan of treatment most generally followed in Germany was the chronic intermittent one; some, however, still belong to the “systematic” school—*i.e.* they only ordered mercury when syphilis manifested itself.

Methods of treatment.—The most popular way of treating syphilis in Germany was undoubtedly by innunction with mercurial ointment; three to five grammes of unguentum cinereum (containing sixteen to twenty-five grains of metallic mercury) were rubbed in daily for forty to fifty days. In watering-places such as Aachen baths were looked on as a most important part of the treatment. In the ordinary out-patient practice and in the military hospitals the patient was usually given one bath on the completion of each “tour”—that is, every fifth or

sixth day; these cases seemed to do quite well on this limited amount of bathing.

The injection treatment was also very largely employed in Germany. A considerable number of preparations were employed, each clinique generally having some favourite one. The insoluble salicylate, sublimate, and grey oil appeared to be more generally used than the others.

Internal treatment by pills and mixtures was not looked on with favour, and was reserved for cases which were obliged to absent themselves from medical supervision.

In cases of "malignant syphilis" Lang did not give any mercury till the general health had been improved and the severity of the disease reduced. To accomplish this he relied mainly on good feeding and the exhibition of his "*Decoctum sarsaparillæ inspissatum*." Two very severe cases of untreated syphilis which I had the opportunity of observing for a month certainly made excellent progress under this treatment, and after about a month were considered sufficiently well to receive injections of grey oil.

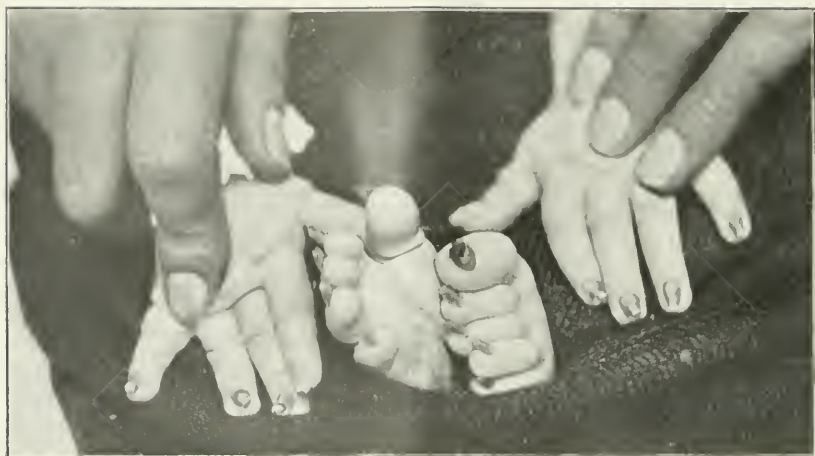
BRUSSELS AND COPENHAGEN.—In these cities, as far as I was able to judge, the general tendency was to form a diagnosis of syphilis from the appearance of the primary lesion without awaiting confirmatory symptoms. The general plan of treatment was on much the same lines as in Germany. Professor Ehlers, in Copenhagen, however, rather favoured intermediate courses of mercurial pills between the inunction or injection courses.

STOCKHOLM.—The most interesting feature here was Welanders' "sack" treatment. As soon as he had diagnosed syphilis, he gave three or four injections of his "mercurial oil" in order to get the patient rapidly under the influence of mercury; the remainder of the course was then carried out by means of his sack treatment. In the case of an adult this was applied as follows: A cotton bag was made sufficiently large to cover the whole front of the chest, the upper end being left open. Each morning this bag was turned inside out and ten grammes of the unguentum cinereum (containing about fifty-three grains of metallic mercury) was rubbed into the side of the bag which was to be worn next to the skin; the bag was then turned back again and the patient wore it for the following twenty-four hours. This treatment was carried out for forty to sixty days, and was repeated at subsequent intervals just as in the case of courses by inunction or

injection. For infants suffering from congenital syphilis one gramme was rubbed in daily. Cases under treatment by this method, so far as one could judge in a visit lasting only a week, seemed to be progressing very satisfactorily. For pregnant women and infants suffering from syphilis, and for whom a course of mercury is essential, the method seemed especially suitable. I would strongly recommend any one who, in the course of his practice, is brought much into contact with this class of case, to pay a visit to Welander's *crèche* for congenital syphilitic children at the hospital St. Göran at Stockholm, in order to see for himself the excellent results obtained there.

ST. PETERSBURG.—At the Kalinkin hospital here the tendency is to diagnose syphilis from the character of the primary inoculation. A large number of the cases are sent in by the police surgeons specially appointed to examine prostitutes; these surgeons naturally had a very large experience in this disease, and consequently were experts in the diagnosis of syphilis. Cases not so sent in frequently present themselves when the disease had lasted some little time, and, in fact, commonly with secondary eruptions. Patients in hospital were largely treated by means of inunction, cases attending as out-patients receiving injections of the insoluble salicylate. I was much struck by the careful records kept of each case, with the dates of previous attendances, symptoms, and particulars of treatment.

Taking a general view of syphilis and its treatment in all places which I visited on the Continent, the one great feature which made the most impression on me was that syphilis, and, in fact, all venereal diseases, were regarded as diseases worthy of serious consideration and entitled to proper treatment, and not as evidences of crime or vice. Everywhere ample provision was made for treating cases in an infective state in hospital. The wisdom of this from the point of view of the general health of the community cannot be denied. I was frequently questioned as to the provision made in London for syphilitic cases; my answer that some forty beds in the lock hospitals was all that we could afford was usually received with a smile of incredulity and brought the further query, "Is there, then, no syphilis in *London*?" For, that in the twentieth century and in the leading city of the world syphilis should exist to any extent without adequate provision being made for its treatment and for the isolation of infective cases seemed incomprehensible to the Continental specialist.



INFANT.



MOTHER.



GRANDMOTHER.

TO ILLUSTRATE MR WILSON'S CASES OF HEREDITARY HYPERKERATOSIS OF THE NAIL-BED.

THREE CASES OF HEREDITARY HYPERKERATOSIS OF THE NAIL-BED.*

BY A. GARRICK WILSON, B.A., M.B.CANTAB., F.R.C.S.ENG.

THE first case I saw was an infant, which was brought to me by its mother (Mrs. G—), for an affection of the nails, and whilst examining them I noticed that its mother's finger-nails were similarly affected. On further inquiries I found that the mother's toe-nails were in the same condition, and that her mother (Mrs. T—), one sister, and two brothers had presented the same peculiarity in the nails of both hands and feet.

The surface of the nails is smooth, and at the base normal in appearance, but towards the free extremity the nail becomes raised up from its bed by a dark, friable, horny mass which projects under the free edge. The nail grows much faster than the horny tissue underneath.

The hair and skin were quite normal in every case, as also were the teeth, and there were no associated congenital defects, such as sometimes occur in these cases. There was no evidence of syphilis, either congenital or acquired, and no signs of past or present ichthyosis or other skin diseases. Examination of the horny tissue from the nail-bed after maceration in liquor potassæ showed the absence of any spores.

The nails cause no pain in themselves, but are very inconvenient. When knocked, the tissue around the nail readily becomes inflamed, and the nail comes off. The new nail at first appears to be normal, but a gradual growth of horny tissue takes place in the nail-bed and raises the anterior part of the nail from its bed.

The affection has been noticed in all the cases at birth and persists throughout the whole of life.

The family history is as follows: The grandmother was an only child, but she had thirteen children, the mother of the infant being the only one now living. Of these thirteen the first two had deformed nails, and the tenth and thirteenth; the first and second were boys and the tenth and thirteenth girls; the mother of our infant is the tenth.

* Read before the Sheffield Medico-Chirurgical Society, November 14th, 1904.

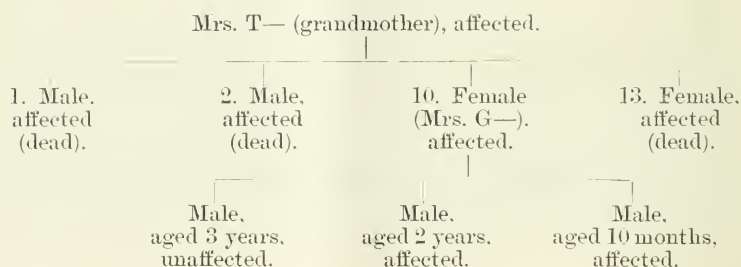
The infant, whose photo I reproduce, was a year old at the time and had a brother, a year and a half older, whose nails were quite normal. Since I first saw the family another male child has been born whose nails are exactly like those in the photograph.

The eldest and the youngest child are strong and healthy, but the subject of our photograph has always been weakly and anemic.

I have been unable to find any record of similar cases, but I believe that cases of hereditary affections of the nails are not very uncommon. I am unable to offer any suggestion as to the causation, and am inclined to put it down as simply an hereditary manifestation.

These cases are always interesting, but I regret that most of the interest lies in the rarity of the case and not in the possibility of treatment.

I have only been able to obtain photographs of the infant, its mother and grandmother; all the other affected members of the family are dead.



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SOCIETY INTELLIGENCE.

THE DERMATOLOGICAL SOCIETY OF LONDON.

AN Ordinary Meeting of the above Society was held on Wednesday, December 14th, 1904, Dr. J. J. PRINGLE in the chair.

The following cases, specimens, and illustrations were demonstrated :

Dr. H. G. ADAMSON showed (1) a photograph of a case of *Dermatitis gangrænosa infantum* with culture of *Bacillus pyocyaneus* from the lesions. Cultures of streptococcus and staphylococcus had also been obtained from the lesions, but the finding of *Bacillus pyocyaneus* was interesting in view of the fact that this micro-organism had already been found by other observers, not only in the secretion from the lesions, but also in the heart's blood and deeply in the lesions on section (Ehlers and Hitschmann and Kreibich).

He also showed (2) a *microscopical section of a lesion of epidermolysis bullosa, showing the probable manner of formation of epidermic cysts*. The lesion was an old healed one with "epidermic cysts," and having at its margin a recent bulla.

(a) One half of the field contained two "epidermic cysts," consisting of an epithelial layer surrounding a mass of concentrically arranged horny cells. The cysts were just below the epidermis and appeared to have no connection with any skin appendage.

(b) The other half showed the formation of a recent bulla. The whole epidermis was detached from the corium, but here and there tags of the epidermis dipping between the papillæ had been broken off and left behind in the corium. The corium itself was very vascular and was slightly infiltrated with lymphoid and connective-tissue cells.

It occurred to the exhibitor that the tags of epithelium, left behind in the corium, and becoming shut off during the healing process, might form the starting point of the epidermic cysts. In a few instances they were seen to have become already completely shut off from the surface of the denuded corium.

According to Darier, however, who examined one of Hallopeau's

cases (1890) the "epidermic cysts" are due to the temporary occlusion of the sweat-ducts by the regenerated epidermis during the repair of the lesion. He states that in horizontal sections the cysts presented an epidermic prolongation downwards, which was recognised as a duct of the sweat-gland.

Certainly the naked-eye appearances of the distribution of the cysts at regular intervals, corresponding roughly to the distance between the sweat-duct openings, seems to support this view. It is possible, too, that the tags as seen in the present specimen may be portions of the epidermis held down by the attachment of the sweat-ducts. In a large number of sections, however, the exhibitor was unable to trace any connection between the sweat-ducts and the cysts or the epidermic tags. Moreover, the sweat-glands appeared normal, which could hardly be the case were the ducts completely blocked—one would expect either atrophy or cystic dilatation.

It is well known that similar "epidermic cysts" may occur in healed lesions of pemphigus, of superficial burns and in cicatrices. These cysts are sometimes called *milia*, a term which is not strictly correct, since by *milium* is generally understood a cyst due to the occlusion of a pilo-sebaceous follicle, *i.e.* a comedo, with no external communication. The "epidermic cysts" here considered certainly have no such relationship with the pilo-sebaceous follicle. Moreover, they are temporary structures, and disappear after a few weeks. Robinson, of New York, however, states that some forms of congenital *milium* are due to the inclusion of a portion of embryonic epithelium either from a hair follicle or from the rete, an observation which is analogons with the exhibitor's view that, in traumatic cases, epidermic cysts may arise from accidentally detached processes of the epidermis.

Dr. GRAHAM LITTLE showed :

(1) A case of a *ringed eruption* in a little girl aged 6 years. On the outer border of the right hypothenar eminence, midway between the wrist and the base of the fifth metacarpal, was a circular lesion consisting of a raised whitish edge enclosing an area the size of a sixpence. In this lesion the border formed a raised, level, unbroken line, about one eighth of an inch broad and one sixteenth of an inch high. The enclosed area was redder than the surrounding skin,

and the surface was rather more marked by furrows than the normal skin, but no definite changes in the skin here could be made out. Since this note was taken, about three weeks before the case was shown, the edge had become red instead of white, but no other change in it had taken place. On the skin over the internal malleolus on the left side there was a similar lesion, that is to say, a roughly circular patch with raised edges, not so prominent as in the case of the hand, and the raised circle was deficient in part of the circumference, fading into the plane of the normal skin; the edge was, moreover, reddish from the beginning. Neither lesion was attended by any subjective symptoms whatever, and these constituted the whole eruption as seen by the exhibitor; but there was a history, obtained by Dr. John Garrett, of Acton, who was kind enough to send the case up for diagnosis to St. Mary's Hospital, of a preceding eruption which lasted for fourteen days and then disappeared, shortly before these patches were noted. This eruption seemed to have been urticarial in character, as far as could be ascertained from the account of the mother. The ringed lesions had persisted since the middle of August. The child perspired rather profusely in the hands, and was not robust, but had had no definite illness.

A section of the skin from the lesion on the foot, which was the less prominent of the two, was obtained, and sections exhibited at the meeting. The sweat-coils were enlarged and were surrounded by a dense collection of connective-tissue cells spreading up towards the epidermis. The blood-vessels were also enlarged throughout the section. There was some hyperkeratosis, but no acanthosis. No other changes were apparent in the section, but further study of the histological features would be required to complete the case. On the day before this case came to St. Mary's, the exhibitor had seen, by the courtesy of Dr. Leslie Roberts, at Liverpool, an exactly similar case, also in a child, and on the ankle. And in the week after the case here recorded was shown, another case was seen at the Children's Hospital, Shadwell, the lesion being single and on the wrist, in a boy aged 3 years. All these cases, it was hoped, would be reported fully later.

Dr. COLCOTT FOX, in commenting on this case and in a communication after the meeting, expressed the opinion that the case noted above and Dr. Pringle's case were the same disease as was present in two cases recorded by him (*Brit.*

Journal of Derm., 1895, p. 91, and *ibid.*, 1896, p. 15). Both of these were children and both had appeared in the summer. All three cases seen by the exhibitor had also been in children and had begun in summer. The latter circumstance might be merely a coincidence, but it supported the suggestion, derived from the sections above described, that the sweat-glands were implicated or were responsible for the disease.

(2) A case of *Pityriasis rubra pilaris* of Devergie in a girl who had been shown while suffering from a previous attack (*Brit. Journal of Dermatology*, 1900, pp. 92 and 412). The present attack was the severest that had been seen in her history and had resisted all treatment, including thyroid-gland administration, which on the other occasions had been highly successful in controlling the eruption. The case was shown as a companion picture to the one shown by Dr. Whitfield at the last meeting.

(3) A case of an affection of the neck which had been shown at the meeting of this Society in July as a tubercular granuloma of the skin, but which in deference to the opinion of the Society on that occasion had been called "an anomalous granulomatous-looking infiltration of the skin of the neck" (*Brit. Journal of Dermatology*, September, 1904, p. 342). The case had been sent to Dr. Wright for vaccine treatment, and the patient had had injections of new tuberculin at intervals of ten or fourteen days (with a prolonged interval during Dr. Wright's holiday) since that time. The practical result, as Dr. Little was kindly permitted by Dr. Wright to record at the Society, had been that at the last estimation of the opsonin reaction, this had increased from an average of .5 to 1.9. *Pari passu* with this improvement the clinical condition had enormously improved, the puckering and thickening of the skin being much diminished and the suppuration entirely absent. The man was also better in his general health as a result of the treatment.

Mr. MALCOLM MORRIS showed a lady suffering from a *peculiar scar-leaving eruption* on the neck and upper part of the chest. The history was that five or six years ago white spots developed on her neck, remaining stationary when once they had appeared. Five months ago there developed a second crop on the neck, and eight months ago she began to notice irritation of the vagina. When shown, the root of the neck in what the French call the

"cravat" region was covered with small white macules of irregular shape, with a slight discoloration round them, though hardly sufficient to be recognised as the lilac areola of morphea. The spots were slightly thickened in some instances, and in others showed central depressions; in all there was an undoubted sclerosis of the true skin. The vaginal mucous membrane was completely transformed into a great area of leucoplakia. The exhibitor asked for diagnoses.

Dr. COLCOTT FOX and Dr. WHITFIELD both considered the case to be one of sclerosing Lichen planus, but some other members considered it to be one of morphea.

Dr. J. J. PRINGLE showed a case of *ringed eruption* of the extremities, a full account of which will be published in this Journal.

Dr. SEQUEIRA showed a young man, aged 26, suffering from *tertiary syphilis* and *leucodermia*. The primary infection occurred four years ago, and the patient had a short course of treatment, but ceased to attend his doctor on the disappearance of the secondary eruption. The nose, at the time of exhibition, was the seat of extensive ulceration mainly confined to the right ala nasi and the right inferior meatus. The tertiary ulceration had lasted for eight months, during which several small pieces of bone had come away from the right side of the nose. The leucodermia, which was the interesting feature of the case, was a broad band, $3\frac{1}{2}$ inches wide, running round the right side of the loin from the lumbar spine to the line of the posterior axillary fold. There had been no eruption in this area recently, and the colour was said to have disappeared coincidently with the first appearance of tertiary lesions. Dr. Sequeira raised the question whether this leucodermia was to be considered a syphilitic phenomenon, or whether the appearance was accidental.

Dr. PRINGLE, Dr. FOX and others discussed the probable relationship.

Dr. WILFRID WARDE showed a middle-aged woman with an infiltrated patch in the right lumbar region of one and a half year's duration. The patch formed a band about 4 inches by $1\frac{1}{4}$ inch running parallel to the crest of the ilium. It was deep red in colour and a little raised above the surrounding healthy skin. The surface showed a number of oval scars which the patient ascribed to the repeated appli-

cation of caustics. There was no apple jelly material. No evidence of syphilis could be obtained. A marked improvement had set in under the influence of a mild tar application, and without any constitutional treatment.

The general opinion of the meeting was that it was a *tertiary syphilide*.

Dr. WHITFIELD brought forward a private patient suffering from an affection chiefly localised to the left side of the face. The history was that the eruption had appeared rather suddenly about six days previously, beginning on the shaved region, so that the patient thought it might be an infection, though he invariably shaved himself, and no one else ever used his razor, soap, or brush.

At first sight the eruption, which consisted of numerous small red papules, suggested a sycosis, but Dr. Whitfield said that he thought that the disease was not in reality a follicular eruption at all. There were, it was true, instances of papules coinciding with the hair follicles, but a close examination showed this to be quite exceptional, most of the papules being situated in the neighbourhood of the follicles, but quite a definite distance from them. The papules were bright red, shotty to the touch, and he thought they were not so superficial as they appeared at first sight, there was no pustulation, and only in a few instances was there any crusting, and this was probably due to the abrasion of the top of the papules by shaving. There were absolutely no subjective symptoms, the disfigurement being the only thing complained of. There was no history or evidence of tuberculosis in the patient or his family. Dr. Whitfield said that this was only the second time that he had seen the patient, and before it had also been by artificial light, so that diagnosis was naturally rendered difficult, but he inclined to the view that this was a mild attack of the disease which had been called acnitis, acne agminata, and hidradenitis, of which terms he preferred the last, as the disease had no connection with the pilosebaceous follicles, and was certainly an inflammation of the sweat-ducts.

Dr. WHITFIELD also showed a photomicrograph from a case of undoubted hidradenitis to illustrate this contention.

The members generally were not very positive about the diagnosis, some agreeing with the exhibitor and others considering that the eruption was too superficial and more likely to be some slight infective process.

THE DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.

A MEETING of this Society was held on Wednesday, November 23rd, 1904, Dr. HENRY WALDO in the chair.

The following cases were exhibited :

Dr. GRAHAM LITTLE showed (1) a case of *Tinea circinata* in an infant, aged 6 weeks. The lesions had appeared three weeks ago upon the lower part of the abdomen and pubic region, on the upper part of the thighs, and over the buttocks. They were nummular in shape, occasionally ringed, and were more than thirty in number. Their size varied from a quarter to half an inch in diameter, while they were of a deep red colour and not markedly scaly. The simulation of a congenital syphilide was remarkable, and was increased by the distribution of the eruption and the youth of the patient. However, a scraping from several of the patches demonstrated with certainty the presence of a ringworm fungus with a peculiarly large mycelium. The source of the infection could not be ascertained. No other children, out of a family of five, were affected.

Dr. EDWARD STAINER, while remarking on the comparative rarity of tinea at such a tender age, stated that he had recently seen a case of *Tinea circinata* in an infant, in which the lesions, although numerous, were only four days old and closely simulated a bromide eruption. He had also seen one case similar to the one exhibited.

(2) A case of *Aene scrofulosorum* in a boy, aged 7 years, who had had the eruption for about eight weeks. The history of hereditary tubercular disease was strong in this case, two aunts, one uncle, and the maternal grandmother having died of phthisis. The patient himself was a delicate-looking lad with enlarged glands in the neck, not explicable by any local irritation. The eruption was made up of the papules which might be regarded as characteristic of the disease as described so excellently by Colcott Fox in his Report to the Dermatological Congress, held in Paris, in 1900: "The essential lesion is a small, extremely indolent granuloma, tending to undergo central

softening and death, and thus leaving scars. The bilateral and symmetrical disposition is notable. The tendency to acro-asphyxia, so common in these cases, and the predilection shown by the eruption for the peripheral regions, when added to the indolence of the lesions and their cellular character, increases the disposition to lividity of colour. The eruption may be scanty or copious, localised or generalised. It may appear on any region, but has a special predilection for the extremities, especially the extensor surfaces. In the great majority of cases the elements are isolated, and any grouping appears to be haphazard." It was quite obvious that the case exhibited fulfilled with close accuracy the criteria thus suggested by Colcott Fox. The eruption was present on the legs, not extending upwards beyond the middle of the thighs, and not found at all upon the upper extremities. The feet and legs were blue and cold. The lesions consisted of deeply livid papules, many of which presented necrotic centres. In no instances were they larger than one eighth of an inch in diameter, and some were much smaller, averaging about a sixteenth of an inch across. They were copiously but irregularly distributed, being most numerous upon the front of the legs.

Dr. Little remarked that he saw this type of disease fairly frequently among the poor and ill-nourished children that came to the skin department of the Shadwell Hospital. From his experience at St. Mary's Hospital, and from that of others in charge of departments of hospitals whose patients were in somewhat better circumstances than those at Shadwell, he believed that *Acne scrofulosorum* was incomparably more frequent among the very poor. Cold had an important influence in determining the outbreak of the eruption, which had been known to recur in the winter and to disappear under warmer conditions. Colcott Fox, in the article referred to, stated that in his cases, collected from the Reports of the Dermatological Society of London, about half suffered "from adenopathies or other marked tuberculous lesions." He was inclined to place the proportion far higher than this, as nearer two thirds than a half of his own cases seemed to show evidences of tuberculosis. The eruption was frequently seen in association with lupus, with tubercular dactylitis, or with scrofuloderma. The duration of the disease was surprisingly variable, being in some cases quite brief. On the other hand, the eruption was known to have lasted in one child for more than two

years. It might thus imitate the short persistence of *Lichen scrofulosorum* or the chronicity of Bazin's disease, both of which were admitted to be of probable tubercular origin.

Dr. STAINER remarked upon the prominence of many of the follicles in this case. He considered that a mild degree of ichthyosis was not unfrequently responsible for the presence of follicular lesions, and pointed out the danger that might occur of mistaking other papular or acneiform lesions for actual tuberculosis.

Dr. T. D. SAVILL showed (1) a man, aged 35 years, with a *persistent ringed eruption*, situated upon the neck, chest, and upper limbs. The condition had lasted for about eight months. The lesions resembled those of *tinea* and also of *syphilis*. No cultures could be obtained. Slight scarring could be observed in the centre of some of the earlier patches. Iodide of potassium had been administered for several weeks without any improvement. Microscopic sections revealed the lesions of *lichen*.

In the discussion which followed the view that the case was probably one of *syphilis* was put forward, but the majority of those present agreed with the diagnosis of *Lichen annularis* suggested by the exhibitor.

(2) A child, aged 11 weeks, the subject of *Urticaria bullosa*. The lesions had almost all disappeared, but undoubted urticarial wheals, accompanied by clear bullæ, the size of a small grape, had been previously observed.

The relationship of this affection to *Pemphigus neonatorum*, both of the simple and specific type, was then discussed, the general opinion being that the term *Urticaria bullosa* should be reserved exclusively for those cases in which definite urticarial wheals or papules develop into or were accompanied by bullæ.

Dr. T. MANNERS-SMITH exhibited a case of *Lichen planus hypertrophicus*. The patient was a carpenter, aged 52 years. The chief lichen patch was situated on the inner side of the right knee; it was of a violet tint, irregular on the surface, and it had a diameter of about two and a half inches. There was a small area of the size of a shilling on the front of each leg. All the patches first made their appearance twenty-five years ago. There were no lichen papules, either around the patches or on any other portion of the skin, nor were there any lesions present in the mouth.

Microscopically, there was seen considerable increase in the stratum corneum, granulosum, and mucosum, slight enlargement of the papillæ, much infiltration of the corium, and some dilatation of the blood-vessels. There was not much increase in size of the papillæ or of the interpapillary processes, in this respect contrasting with *Lichen planus verrucosus*.

EDITORIAL.

WITH the issue of this number of the *British Journal of Dermatology* an important change has taken place in its management, and the editorial chair is the poorer by the resignation of Dr. James Galloway, who has guided the Journal with eminent success during the last nine years. It was in 1896 that Dr. Galloway became the active editor of the Journal; and every reader of it is well aware of the able manner in which it has been conducted during his tenure of office. But it is by those most intimately connected with the management of the Journal that his loss will be chiefly felt. It is with great satisfaction, however, that we are able to announce that though Dr. Galloway has been compelled by stress of public and private work to vacate the editorial chair, his valuable counsel and influence will not be lost, for he has consented to retain his seat on the Editorial Committee.

The Editorial Committee has been strengthened at this time by the addition to its number of Mr. Arthur Shillitoe and Dr. Edward Stainer.

With this number also the Journal appears in a somewhat new form. The page has been widened, and in this way a larger margin around the printed matter has been obtained, and more space is available for the reproduction of illustrations.

This is the only British journal dealing exclusively with the diseases of the skin. Its object has been to represent the progress of Dermatology in this country, and to furnish a record of the work done in this branch of medicine. It has been altered in detail from time to time as occasion demanded, but its policy has remained unchanged, namely, the advancement of British Dermatology. The Journal can look back on a past record of invaluable work, and it is hoped that it may long continue to live up to its traditions.

HISTOLOGICAL NOTE.

MITOSIS IN MAST-CELLS.

BY L. H. HUIE.

As far as I am aware there is no record of mitosis having been observed in mast-cells.

While examining the developing skin-tissues of mice before and after birth my attention has been attracted by the mast-cells, which are here larger and more numerous than in human material. By suitable staining I find that their nuclei contain one or two small nucleoli and a fine wide-meshed chromatin network which varies much in amount in different cells. When mitosis occurs the cell enlarges, and the granules retreat to its periphery. At the diaster stage they outline the two daughter cells, forming thus a figure of 8. In the resting stage the granules are usually more numerous than during cell division, and often conceal the nuclear structure entirely. The stains I have used are Unna's polychrome methylene blue, and toluidin blue in 1 per cent. solution. To demonstrate the dividing nuclei I left sections in the latter stain for 10-12 hours, and decolourised in glycerine-ether. I also employed for this purpose Heidenhain's iron-alum hæmatoxylin, and after well washing out applied one of the other stains for the granules. So far I have not observed mitosis in the mast-cells of pathological conditions of human skin.

CURRENT LITERATURE.

ON INOCULATION EXPERIMENTS WITH SYPHILIS ON THE ANTHROPOID APES. LASSAR. (*Dermat. Zeitschr.*, Bd. xi, January, 1904, p. 3.)

THE experiments related in this paper were carried out on a healthy male chimpanzee of four or five years of age. The subject from whom the material was taken was a man who had had the misfortune to be accidentally inoculated with syphilis on the arm during the process of tattooing, and an almost aseptic sore followed by general infection was the result. Owing to the danger, in the event of successful inoculation, to attendants on the animal from possible bites and scratches the subject from whom the material was taken arranged to look after the animal. The inoculations were attempted as follows: First a piece of

tissue taken from the chancre was inoculated with some of the tissue juice in the upper lip; secondly, another piece was well rubbed into the junction of the frenulum and the lower lip. A small piece was also allowed to dry into a cut in the skin just above the root of the nose, and an inoculation was attempted into each eyebrow. Finally some of the serum was inserted into a pocket above one eyebrow and the rest used to scarify the right ear in three places. On only two places, above the eyebrows, did anything happen; and here, after fourteen days, raised infiltrations made their appearance and underwent a central breaking down and showed all the characteristics of a syphilitic chancre in man. When shown, six weeks later, to the Berliner medizinische Gesellschaft there was a typical eruption affecting the hands, feet, and anus, although the animal seemed very well in health. After the demonstration one of the primary lesions was excised and examined histologically and showed all the characteristics of a primary chancre. There is a coloured plate and microphotograph of the lesion.

A. W.

ON A PARTICULAR FORM OF LINEAR SKIN ERUPTION. By
FELIX PINKUS. (*Dermat. Zeitschr.*, Bd. xi, Heft 1, January, 1904, p. 19.)

THE patient was a coachman, aged 26 years, who came suffering from an eruption running down the outer side of the left thigh. The eruption was of about fourteen days' duration, and began with severe itching and the appearance of a band of red nodules reaching from the hip to the knee. Four years before he had acquired syphilis, of which the last symptom had disappeared three and a half years ago. He had been under constant supervision since and had undergone the chronic intermittent form of treatment for his syphilis. The eruption was found to extend from the region of the great trochanter downwards and forwards to the right patella, where it ended. The band of eruption was of the breadth of the palm of the hand at its widest part, and consisted of branches which reunited again. It was composed of small round efflorescences, which were for the greater part arranged in groups of from three to ten units. The individual lesions were without apparent connection with the appendages of the skin, were situated in the skin, of the size of a pin's head, round in shape, not very much elevated, mostly flat, but occasionally pointed, light reddish brown in colour, slightly transparent, not scaling, but a few showed little light brown, hard crusts, as if from dried-up vesicles, with slightly purulent contents, and the skin in between was normal. The eruption healed slowly in a few months under a tar-zinc paste. A group of nodules was excised for examination and showed the presence of a mild form of dermatitis especially affecting the vessels which were surrounded with small cells. Some serous and leucocytic exudation was present, and there was parakeratosis, with here and there slight acanthosis. The nerves were apparently unaffected. The author refers to other cases, and comes to the conclusion that this is a special form of eruption, with its own clinical course and histological features.

A. W.

ATROPHODERMIA ERYTHEMATOSA MACULOSA (LICHEN PLANUS ATROPHICUS). WECHSELMANN. (*Dermat. Zeitschr.*, Bd. xi, January, 1904, p. 29.)

THE patient was a man, aged 35 years, who had suffered from severe headache in consequence of a rhinitis with suppuration of the frontal sinus. The pus

burst through into the nose and this condition got well, but he was then attacked with the eruption on the affected side of the face, and this spread until it had the following distribution: On the forehead, the scalp by the temple, and in front of the left ear were a number of spots, partly white and partly red. The red spots were always on the periphery and showed as pea-sized, scarcely elevated, lesions. In other parts the redness was replaced by pigment which surrounded a slightly depressed white scar. Over the superior internal angle of the scapula was a group of Lichen planus papules as large as a five-shilling piece, with some scattered papules round it. The histology was that already described by Darier under the name of Lichen atrophicus. The chief interest lay in the support which the history gave to the nervous theory of the origin of these cases.

A. W.

ADVANCES IN LIGHT TREATMENT. STREBEL. (*Dermat. Zeitschr.*, Bd. xi, January, 1904, p. 30.)

THIS paper contains a series of suggestions as follows:—

1. The use of "electro-photo-caustic," namely the heat-rays which emanate from the arc. The current may vary from two ampères at the least to twenty ampères at most. The diseased tissue, having a less active circulation of blood, is more easily burnt than the healthy, and hence the method becomes a truly selective one. A temperature of 400° can be easily obtained. The method is recommended for superficial malignant and benign growths, foul ulcers, and single nodules of tuberculosis. The surrounding skin may be protected with hollow cooling diaphragms, and the burn thus localised does not demand anaesthesia. (It is worthy of note that the *method* as well as the lamp is under provisional protection, as a patent has been applied for.—A. W.)

2. A better method for introducing the light into small cavities by means of a series of quartz rods or by means of one curved rod. The light is led down the centre of the tube after the manner that was suggested some time ago for microscopic illumination. (Patent applied for.)

3. A new form of lamp which does not appear to call for special notice.

4. Remarks on the theory of light treatment. Strebel thinks the chief action is that of a stimulant to the trophic nerves of the part, but possibly also by the products resulting from the destruction of the albumen acting as poisons to the hostile organisms.

A. W.

MYCOSIS FUNGOIDES. SERENI. (*Dermat. Zeitschr.*, Bd. xi, January, 1904, p. 41.)

THIS is the report of a case of mycosis fungoides of the *d'emblée* type, occurring in a girl sixteen years of age and terminating fatally in two and a half years. There is nothing new in the results of the investigation, which was very complete. Under the heading of Treatment no mention is made of the benefit which has accrued in some cases by the use of X-rays.

A. W.

ON THE SO-CALLED BENIGNANT SARCOIDAL GROWTHS OF THE SKIN (BOECK). P. A. PAWLOFF. (*Monatshefte f. prakt. Dermatologie*, May 15th, 1904, p. 469.)

THE cases belonging to the above group which have been described in the last

few years by Spiegler, Fendt, Boeck, and others, although they differ in microscopical construction, prognosis and course from genuine sarcomata of the skin, do not present any uniform histological or clinical picture, and the various cases show considerable differences. The name "sarcoid" is, moreover, open to the objection that it seems to assume some relationship with sarcomata, whereas it merely serves to denote a group which is not generally understood, unless the name of Boeck is added. An additional case is, however, of interest, and the one in question is that of a book-keeper, aged 25 years, who first came under observation on April 15th, 1895. He states that in 1893 there first appeared on the skin of the left leg some reddish-brown small patches, which were painless. Later on in the neighbourhood of these patches there appeared a marked swelling, and œdema of the middle third of the leg. Pressure with the finger caused pitting, and a blow caused acute pain. At the beginning of 1895 nodules appeared on the left leg, which, however, were not enough to send the patient to the doctor. Only the growths which showed themselves at the end of March compelled him to seek advice.

When examined, the leg presented a localised swelling, the skin appeared stretched, shiny, and could nowhere over this area be raised into folds. At a distance of 5 mm. from the malleoli the diseased area was sharply raised from the healthy skin and marked off from it. Above, the limits of the diseased area were less sharply defined. Numerous flat nodules, varying in size from a bean to a walnut, but imperfectly felt through the swollen skin, were scattered over the arm, some isolated, but others running together to form distinct infiltrations. Older nodules on their way to involution showed central depressions, softer in the middle than at the periphery. Dark brown pigment patches, as large as a finger-nail in places, were also present in some of the nodular depressions. Smaller pigmented spots were also present in the centre of the more recent nodules, and were covered with a thin horny layer. Yellowish pigment was also present over the swellings of the middle third of the leg, where no definite nodules were to be found. A dry horny layer covered the whole of the diseased area, thicker over the larger nodules, and in places of a purplish red colour. The glands of the thigh and the inguinal glands of the left side were enlarged.

Microscopical examination of a nodule showed dense infiltration of the deeper layers of the skin and subcutaneous tissue and of the middle layers of the corium, extending from the upper limits of the infiltration quite up to the pars papillaris, arranged closely round the vessels. This infiltration was made up of various connective-tissue cells, solitary leucocytes occurring but rarely, and mast-cells far from frequently. In places fibroblasts were in the majority, and small islands were found of a uniform cloudy appearance, which showed up by reason of their somewhat intense staining with eosin. Corresponding to these islands were found a considerable number of unicellular and multicellular leucocytes. The islands showed some resemblance to hyalin degeneration. In the midst of the epithelioid cells, and not far from these islands were some giant-cells, containing in some cases as many as 30 to 40 nuclei.

The elastic tissue was distinctly diminished in the area of infiltration, and only in parts could untouched perfect elastic fibres be found.

As regards diagnosis, primary sarcomata of the skin and sarcomata of the Kaposi type could be eliminated by reason of the course and termination of the lesions and the character of the pathological changes. Mycosis fungoides, multiple

gummata, and tuberculides were also excluded, and a positive diagnosis was reached after consideration of the pathological structure and course of the lesions, and the excellent results obtained by the administration of arsenic, which practically cured the disease.

J. L. BUNCH.

KERATOSIS CIRCUMPILARIS (KÉRATOSE PILAIRE ENGAINANTE). Prof. AUDRY. (*Monatshefte f. prakt. Dermatologie*, June 1st, 1904, p. 530.)

THE case is one of an eight-year-old boy, born in the Argentine of healthy French parents. For the last two years he has been living in France, and has only had röteln and perhaps small-pox. He is small for his age, but otherwise healthy.

According to his mother's account, the present illness began two months before, at the back of the neck, where it has remained localised. At this point the skin is covered with small dry, hairy, yellow lesions, while the surrounding skin remains healthy. The lesions are about 2 mm. high and have the thickness of a substantial horse-hair. On passing the hand over the sensation is as of a stubbly beard. Each element corresponds to a hair-follicle. The affected area extends from the hair margin to the seventh cervical vertebra, and from one angle of the jaw to the other. When the lesions are recent the elements form small white masses such as one meets in keratosis pilaris. Each one is traversed at its centre by a white, shining, downy hair. There is no pain and no itching. At the sides of the thorax and abdomen one finds a few typical keratosis pilaris lesions, otherwise nothing abnormal.

On tearing out these elevated masses and examining in potassium hydrate or Ranvier's picrocarmine, we find them to be elongated, and composed of horny lamellæ, closely applied one over the other like slates. The free end is traversed by an axial canal, opening near the termination, in which lies the small hair, not quite reaching the end of the canal. Excentrically from this canal lies a second, which is much smaller, also containing a thinner hair. The hair which lies in the axis of the canal can be traced to its origin, *i.e.* to the base of the small plug. It has a complete bulb, which is somewhat brush-shaped.

A small piece of skin was excised, hardened in alcohol, embedded in paraffin, and cut in series and coloured with picrocarmine, polychrome blue and safranin. The epidermis was quite normal, showing hardly the smallest trace of hyperkeratosis. All the hair-follicles were altered, and all in the same way. They were dilated and full of concentric horny layers crowded round the central hair. The follicle sheath was formed of cells, which were continuous with the "schleimschicht" and maintained its original characters. The eleidin, which was easily visible in the epidermis, did not extend beyond the neck of the follicle; therefore the horny formation preceded actively the appearance of the eleidin. The basal membrane entirely lost the regular cylindrical arrangement of its elements. In one preparation the eccentric hair was already at its point of exit surrounded by two or three leaf-like rows of cells containing small and flattened nuclei.

In the outermost lamellæ of the horny masses one found numerous degenerated nuclei, giving a parakeratotic appearance.

In the neighbouring connective tissue small inflammatory processes were encountered. Traces of glands or hair-follicles were nowhere found.

Treatment with tar and pyrogallol ointment cured the disease in a month. In view of the microscopical appearances and the presence of follicular plugs a peculiar form of keratosis pilaris was undoubtedly involved—one not previously described. But in this case the hyperkeratotic lamellæ formed a sheath round the hair instead of filling the follicle and closing in the hair. Such an anomaly is difficult of explanation.

J. L. BUNCH.

SEBACEOUS GLANDS ON THE INNER SURFACE OF THE PREPUCE. DELBANCO. (*Monatshefte f. prakt. Dermatologie*, June 1st, 1904, p. 536.)

IN people of middle age with an irritated foreskin which is rich in smegma one often finds on the inner surface of the prepuce a number of fine yellow masses, whose microscopical examination confirms the clinical diagnosis. They are, indeed, numerous isolated sebaceous glands. They are best seen by drawing the prepuce firmly back, and cleansing the internal surface. They usually surround the frenulum, and are less numerous as one gets farther from it. They are to be distinguished from the whitish-yellow small projections arranged in rows on the corona glandis, which are well known to every urologist, and which are of quite different nature.

J. L. BUNCH.

A CASE OF LICHEN PEMPHIGOIDES. Professor S. MENDES DA COSTA. (*Monatshefte f. prakt. Derm.*, June 15th, p. 581.)

IT is well known that both a vesicular and a bullous form of lichen occur, but that a lichen eruption can be entirely composed of bullæ, as in pemphigus, is less well known. The following is such a case. The patient was first seen on February 14th, 1903, for two small but typical lichen patches, one on each forearm, which had developed in the course of four months. Plaster mull treatment caused at first some improvement, but new polygonal papules began to develop, and as these increased the old patches disappeared. At this period too there appeared a light degree of rosacea and seborrhœa of the nose and cheeks.

Treatment with Fowler's solution up to twenty drops a day and various ointments did not check the eruption, which spread so much that at the end of May only a few healthy spots could be found on the swollen, red, and itching extremities. Under continued arsenic treatment the pigmentation of the centres, especially of the lichen patches, became more marked. Towards the end of May many of the patches of lichen became surmounted with flat bullæ in the centre, the edges of the patch remaining bluish-red. In the next few days more blisters appeared and some of them became hæmorrhagic. Up to now all the blisters had made their appearance on lichen patches, but henceforth it was noticeable that they also were present on healthy skin. And as the number of bullæ increased, so the number of lichen efflorescences diminished. The old lichen patches diminished and disappeared, until by June 4th only bullæ, pigmentation, and œdematous swelling were visible. The appearance was now one of pemphigus. The bullæ were in some places as big as a watch-glass, the contents were colloid or serous and in most cases hæmorrhagic. The whole surface of the skin was brownish and thickened, covered with bullæ, or the remains of bullæ, and white

or pinkish spots where bullæ had healed up. The mucous membrane of the mouth and throat also showed bullæ which for long remained intact and were filled with gelatinous substance. One of the bullæ in the throat placed the patient's life in danger, but the danger passed off without operative interference. The hair of the scalp fell out and the nails ceased to grow. There was no albuminuria and no eosinophilia of the bullæ contents; Nikolshi's phenomenon was absent. The general condition remained good.

Treatment with ergotin, belladonna, morphia, etc., internally was useless.

On June 26th arsenic injections were commenced every day, and the patient's condition improved inasmuch as the new bullæ were smaller and not hæmorrhagic. They still, however, developed in great numbers, some of them resembling those of herpes iris. When no more healthy skin remained to make injections into (only a portion of the face still remained free) and also because the injections caused pain and did little good, this treatment was given up and Asiatic pills ordered. From July 26th to September 12th they were given in increasing doses up to 75 mgr. arsenious acid per day. Under this treatment improvement set in. The number of bullæ decreased, but the pigmentation and seborrhœa of the face increased. The hair began to grow again and also the nails. After 75 mgr. had been taken for some weeks, the dose was gradually diminished again down to 30 mgr.

With the improvement the mobility of the skin increased, so that at this time Nikolshi's phenomenon became quite evident. Most bullæ developed after slight traumata.

After arsenic had been given for some weeks longer, signs of intolerance came on, dryness of the throat, cough, and suppurative folliculitis. At the beginning of November it was discontinued. But for six weeks a few bullæ appeared every day, so arsenic was re-commenced in the form of Bourboule water. No fresh bullæ now appeared, but some flat Lichen planus nodules developed, after an absence of such phenomena for six months. These disappeared in four weeks and afterwards only an occasional urticarial lesion made itself visible. Lichen nodules and bullæ have not reappeared.

Opinion is still divided as to the meaning of bullæ in lichen; they are met with too frequently in lichen for them to be a mere coincidence. It is also improbable that they are of infectious origin and occasioned by injuries, since Leredde has shown that they develop on spots protected by bandages, when the skin is healthy, and they remain serous for some days. It is more probable that the bullæ are a further stage in the development of lichen, and when this stage is reached universally no more papules can be found. It may be concluded that lichen is not a monomorphic but a polymorphic disease, although the monomorphic form is the one which usually makes its appearance.

J. L. BUNCH.

THE TREATMENT OF SYPHILIS. H. M. CHRISTIAN. (*St. Louis Med. and Surg. Journ.*, June, 1904, p. 305.)

THE writer of this paper believes that it is safer to wait for the evolution of cutaneous lesions before beginning constitutional treatment in syphilis than to begin before the diagnosis is certain; since he considers that the early administration of mercury does not in any way avert or prevent the appearance of

the eruption, while it modifies the character and time of development of the skin manifestations and renders the diagnosis more difficult. In exceptional circumstances, however, when the chancre is located on the lip, or the finger of a surgeon where it may infect others, or becomes phagedenic, then immediate treatment with mercury is recommended.

In mild cases the treatment favoured is the administration of mercury protoiodide, one-third of a grain in a pill three times a day. If this be insufficient to cause the rash to rapidly fade a fourth pill is given at bedtime. In more severe cases, where there is a constant tendency to the recurrence of mucous patches on the tongue, lips and buccal mucosa, an extra pill is prescribed every other day until the teeth become tender or the gums bleed when lightly touched. The number of pills required to attain this is then divided by two and the result constitutes the daily tonic dose. In still more severe cases inunctions of mercurial ointment are resorted to, but to avoid causing a dermatitis the skin should be thoroughly cleansed with green soap and alcohol prior to using the inunction.

The writer regards the protiodide pill as superior to the familiar mercury and chalk pill.

After one and a half years of active mercurial treatment the patient is placed on the mixed treatment, namely $\frac{1}{20}$ grain of biniodide of mercury and 5 grains of iodide of potassium, three times daily, and this is kept up for one year. In cases of ulcerating syphilodermata and gummata the writer recommends twelve-grain doses of iodide of potassium three times daily with mercurial inunctions twice a day.

J. M. H. M.

LUPUS, CARCINOMA, AND X-RAYS. NORMAN WALKER. (*Scot. Med. and Surg. Journ.*, July, 1904, p. 5.)

UNDER the above heading the writer discusses the important subject of the development of carcinoma in cases of Lupus vulgaris in a clinical lecture delivered at the Royal Infirmary, Edinburgh, in June, 1904. Notes of four cases under the writer's care are given in which lupus was complicated by carcinoma. This association has been noted by numerous observers, and the writer considers that it is even more common than is supposed on account of the number of cases which are unrecorded. The writer's chief object in choosing this as the subject for a clinical lecture was to discuss the question of the possible connection between the development of the carcinoma and the treatment to which the lupus had been subjected. The writer considers that cancer growth in the skin may take its origin from "buried epithelioma" in the Cohnheim sense, and that portions of the proliferated epidermis in a case of lupus, which have become cut off in the process of healing and scarring of the lupus become "cell-rests," and are capable of malignant development. According to this theory, scraping of a lupus, which might easily be responsible for portions of epidermis being broken off and snared in the scar-tissue, might reasonably be regarded as a cause of the malignant proliferation. Then there is the possibility of the X-rays being responsible for the cancer, as they may do in a healthy skin. On this point the author points out that the cancer, which has too frequently developed in the case of those constantly working with X-rays, is an epithelioma associated with hyperkeratosis, which is capable of rapid increase and speedily involves the glands, while the

cancer in the lupus-scar is more papillomatous and does not affect the glands so much, but extends locally. The types of cancer in the two cases are different, and the cancer in the lupus-scar seems to the writer to be indirectly produced by a scraping off of epithelial cells in the process of scarring, and not by the direct action of the X-rays. This view is supported by the fact that persistence in treatment "may directly cure the condition which it has indirectly produced."

J. M. H. M.

REVIEWS.

ELEMENTS OF GENERAL RADIO-THERAPY.*

THE name of Leopold Freund of Vienna has been so intimately connected with X-ray therapeutics during the last six years, and is so well known to every worker in the subject, that it requires no introduction here. It is with great pleasure that we welcome an English edition of his text-book. Freund was one of the first to recognise the possibilities of the X-rays in treatment, and has a distinct claim to be regarded as one of the founders of X-ray therapeutics. While Finsen was carrying on his classical experiments in Copenhagen on the action of light on the skin and its therapeutic value, Freund was experimenting on similar lines with the X-rays; and now after the lapse of six years, we have before us a record of his experience and results. There is much in this account of "arduous theoretical and practical work" which is of paramount interest at the present time; but space will only permit us to touch on a few points of special importance, and to refer briefly to the general scope of the work.

The book does not consist solely of the author's experiments and deductions, but embodies a critical and full survey of the observations of others in the same field. In the Introduction the writer gives the following definition of the visible clinical effects due to radiations:

(1) The physiological effect of a radiation stands in direct relation to its intensity, but in inverse proportion to its wave length; and (2) the degrees of reaction only become visible after a latent period, the length of which stands likewise in inverse proportion to the wave length and intensity of the radiation employed. The writer defines radiant energy as a form of activity produced by regular and rapid vibrations of an imponderable substance, ether, which permeates space and matter. Certain other radiations, however, for example, the cathode rays, he believes to be small material particles charged with negative electricity. The whole subject is in such a state of evolution at present, and so beset with difficulties, even to the expert physicist, that the author, in view of the fact that the book is essentially one for the physician rather than the physicist, wisely devotes the initial chapters to the physical aspect of the subject, and presupposes a comparatively slight knowledge of it. He describes the elements of electricity, and goes into considerable detail over condensers, electric machines, accumulators, magnetic effects of electric currents, interrupters, and coils.

* *Elements of Radio-Therapy.* FREUND. Translated by G. H. LANCASHIRE. London: Rebman, 1904. Price 21s. net.

In connection with high-frequency currents he describes a series of experiments which go to prove that spark discharges with the electrode at a moderate distance, a strong, high-tension primary current, and a sufficiently quick rate of interruption, can destroy bacterial cultures several days old and fully developed. The histological effects of spark discharges on a rabbit's skin are also described, and the following changes are noted: (*a*) A small-celled infiltration in the deeper layer of the epidermis; (*b*) an extensive extravasation of blood; and (*c*) a vacuolisation in the intima of the arteries. These changes are very similar to those which have been recorded frequently in X-ray dermatitis. With reference to the therapeutic value of the high-frequency currents, the author is most guarded. He does not go quite so far as Strauss in believing that the treatment of pruritus is their only legitimate use, for he finds them useful in drying up indolent ulcers, though not in actually curing them. We are at one with the writer in strongly deprecating the sensational rumours which have emanated from certain quarters that high-frequency currents have succeeded in curing pulmonary tuberculosis, rumours chiefly based on the fact that they are capable of destroying bacteria. "What succeeds in a laboratory often fails entirely in clinical practice."

In his chapters on the X-rays the writer gives some valuable hints to the beginner, and one of the most important is the advice in X-ray treatment, never to work with currents greater than three ampères. With regard to the estimation of the intensity of the current, the writer still relies more on the character of the fluorescence in the tube than on instruments of the type of the radio-chromometer of Benoist. With this statement we are far from being in agreement; for to trust to the character of the fluorescence as seen by the naked eye, cannot be so satisfactory as to employ an instrument such as that devised by Benoist and recently improved by Wehnelt, or to insert a galvanometer in the secondary circuit; besides, by these instruments the intensity of the rays can be recorded according to a fixed standard.

In discussing the various skin affections which are amenable to X-ray treatment, we note that Freund still advocates the employment of the X-rays in hypertrichosis, and recommends repeated series of exposures at intervals of six weeks for a year or more, till such a time as the hairs cease to grow again after the exposure. This procedure is one, however, of considerable risk, and should not be lightly undertaken without warning the patient of the possibility, even probability, of producing an alteration in the texture of the skin and a wrinkling which may be almost as disfiguring as the hypertrichosis, if not more so, not to speak of the danger of a dermatitis. We consider that any but the most experienced operator will be wise to be content with electrolysis, and refrain from running unnecessary risks with a method which is capable of doing incalculable harm. We note also, with interest, that the writer is strongly in favour of the employment of high tubes and a small current in the treatment of *Lupus vulgaris*, so as to avoid the production of a dermatitis. With regard to the precise radiations from the tubes which act on the skin the author believes—and his belief is based on a series of experiments—"that of all the physical factors emanating from an X-ray tube, only the Röntgen-rays themselves and the discharge of high-tension electricity from the tube surface can be considered responsible for the physiological effects; both these agents appear simultaneously while the tube is working, both have demonstrably similar effects, and these effects supplement and accentuate each other."

The subject of photo-therapy is also discussed at considerable length, and the Becquerel rays from radio-active substances are referred to.

The volume is well illustrated with regard to blocks of apparatus, but the photographs of patients are, unfortunately, not well reproduced, and the histological illustrations are ill-defined and of little value.

Dr. G. H. Lancashire is to be heartily congratulated on his translation, which is so well done that the fact of its being a translation is scarcely noticeable in the reading of it; and we owe him a debt of gratitude for bringing this valuable work so prominently before the medical profession of this country.

MEDICAL ELECTRICITY.*

It is with great pleasure that we welcome the fourth edition of this well-known and useful handbook on medical electricity. The subject, especially that branch of it which is of greatest interest to the readers of this journal, namely, radio-therapeutics, is advancing with such rapidity that new editions of our standard works on the subject at comparatively short intervals become a necessity. This edition brings the handbook again up to date. In it the author has dealt more fully with the subject of the X-rays, and has added chapters on high-frequency currents and on the utilisation of electric-light mains for medical electrical work. The book is too familiar to all workers on the subject to require any reference to its scope and general arrangement, and we will content ourselves here with referring only to those sections of it which bear most closely on the treatment of skin affections. The writer, like several recent authors, takes what seems to us to be a too hopeful view of the value of high-frequency currents in the treatment of cutaneous disorders. He states that "the morbid states of the skin in which success has been most commonly obtained with high-frequency treatment are pruritus, Lichen circumscriptus, psoriasis, eczema, acne, sycosis, and lupus," and in the healing of ulcers. These beneficial effects he regards as due to stimulation or counter-irritation, perhaps the generation of heat, and the production of ozone and oxides of nitrogen at the actual skin surface. We trust that further experiment will bear the author out in these opinions. The utility of these currents has been proved beyond dispute in pruritus and the healing of ulcers, but in the other diseases mentioned, though benefit from them may occasionally have been recorded, still more certain results can be obtained by much simpler and less costly means.

The description of the treatment of nævus by electrolysis is clear, and contains many valuable hints. We heartily endorse the writer's opinion that to electrolyse a capillary nævus in such a manner as simply to cause it to slough completely away is bad treatment, and that the larger ones should be done piecemeal and the current carefully applied till coagulation of the blood is produced, and stopped short of producing general necrosis and sloughing, and that where possible it is better to excise them.

In the section on X-rays special reference is made to the important subject of measuring the quality and the quantity of the rays by means of Benoist's radio-chromometer (an improvement of which has recently been introduced by Wehnelt).

* *Medical Electricity*. By H. Lewis Jones. Fourth edition. London: H. K. Lewis, 1904. Price 12s. 6d. net.

and the chromo-radiometer of Holtzknecht. The most satisfactory device of all, according to the writer, is a specially constructed galvanometer, which will carry the current of the coil, inserted between the coil and the tube. This registers the exact current passing through the tube, and the amount of rays given out by the tube has been proved to be proportionate to the actual current in this circuit. The therapeutic applications of the X-rays are discussed at considerable length, and there is an interesting section on radium, its action, physiological effects, and therapeutic value.

The letterpress throughout is clearly written and convincing, and bears indication of a large experience of the subject and a capacity on the part of the author for expressing his ideas in a concise and simple manner. The illustrations are good, and the publishers are to be congratulated on the excellence of the printing and the freedom from printer's errors.

THE DIFFERENTIAL DIAGNOSIS OF SYPHILITIC AND NON-SYPHILITIC AFFECTIONS OF THE SKIN.*

WE have read Mr. Pernet's small volume with interest and pleasure. It is based on a paper read by him in 1900 at the Medical Society of University College. This paper he has been induced to elaborate and issue in book form. The book is primarily intended for students and general practitioners, and to such readers it will be most useful: but it contains matter also which cannot fail to interest the expert. The method of examining a patient suffering from a skin disease is first considered, and forms the subject of a valuable chapter. Before discussing the differential diagnosis of the cutaneous signs of the various stages of syphilis, the writer gives a careful description of the skin-lesions of that stage. While admitting the doubtful value of an arbitrary division of the syphilitic manifestations into primary, secondary, and tertiary, he considered those headings as useful "finger-posts" round which to group certain types of lesions. The descriptions of the cutaneous affections of the disease are concisely written. The differential diagnosis, however, is perhaps unnecessarily detailed and elaborate for its purpose, and so many rare affections are considered which are unlikely to come within the cognisance of the student or the general practitioner, that there is a danger of rather confusing than assisting any but those well-initiated in cutaneous disease; for not only is the differential diagnosis discussed between various syphilides and such unusual affections as Plantar trichophytosis, Acne agminata, and Psoriasis rupioides, but even rare tropical conditions, such as trypanosomiasis, are dragged in. The volume is nicely got up, and the printing is good. With regard to the proof corrections, we think that it is unfortunate that the doubtful spelling "seborrhœic" should be persisted in, when the name Eczema seborroicum, without the diphthong, appears in the same page. We also take exception to the statement that Lupus erythematodes is an erythematous form of Lupus vulgaris: Lupus erythematodes is an occasionally used synonym for Lupus erythematosus: the author obviously refers to the L. érythématoïde of Leloir. There is also a tendency to loose statements which we deprecate, such, for instance, as the remark that "the fungus in Tinea barbæ is Trichophyton

* *The Differential Diagnosis of Syphilitic and Non-Syphilitic Affections of the Skin.* By G. Pernet. London: Adlard and Son, 1904. Price 6s. 6d.

megalosporon ectothrix, at least, in my experience," when a number of cases have been reported in which the fungus was an endothrix with violet culture; or the statement that histologically the growths of Verruca Peruana are neither warts nor granulomata, when the lesions of this disease, in the experience of more than one observer, belong to the latter category.

Apart from a few minor defects of this nature, which could easily be remedied in a future edition, we congratulate the writer on having produced a readable book which will be of value, not only to students and general practitioners, but to all those who are interested in cutaneous diseases.

SYPHILIS AND GONORRHOEA.*

In this volume of 267 pages the author has presented an up-to-date account of syphilis and gonorrhoea. The description of each disease is prefaced by a chapter on the history of it. These, though they may prove of interest to a certain morbid type of reader, seem to us to be unnecessarily detailed, for there is much in the history of venereal diseases which is of little importance and doubtful value to the scientific student. The actual descriptions of the diseases are tersely written. After discussing the pathology and bacteriology of syphilis, and referring to the recent inoculation experiments on monkeys, the writer goes on to describe the differential diagnosis of the cutaneous syphilides from the various skin affections with which they may be confused. To discuss the differential diagnosis of a disease before describing its objective signs seems to us, however, to be a questionable procedure, and, in the common parlance of every-day life, to be putting the cart before the horse. A useful chapter deals with the difficult problems of "Syphilis and Marriage" and "Syphilis and Life Assurance." With regard to treatment, the writer advocates waiting till secondaries appear before commencing treatment, unless the sore be a typical Hunterian hard sore. Like the majority of British writers, he prefers the administration of mercury by the mouth to inunctions and intra-muscular injections, unless in severe cases, and begins with three months' continuous treatment, followed by two or three weeks' rest, then another three months' continuous treatment. After this the treatment is regulated by the presence or absence of symptoms. With regard to hereditary syphilis, he considers that the treatment should be symptomatic throughout.

The last chapter of the book is devoted to a discussion of "Venereal Disease in the Army and Navy." Here, again, the author is on thin ice.

The get-up of the book is excellent: the type is large and clear, and the letter-press is lucid and readable.

DISEASES OF THE SKIN.†

RUMOURS of a new and revised edition of Hyde and Montgomery's *Practical Treatise on the Diseases of the Skin* reached us months ago, and we have been looking forward with great interest to its arrival. The book is so well known

* *Syphilis and Gonorrhoea*. By C. F. Marshall. London: Rebman, 1904. Price 8s. net.

† *Diseases of the Skin*. By James Nevins Hyde and Frank Hugh Montgomery. Seventh edition. Philadelphia and New York: Lea Brothers and Co., 1904.

and so deservedly a favourite on this side of the Atlantic that it requires no words of introduction from us. In 1902, when we reviewed the sixth edition, we felt that the fact that the writers had found it necessary then to issue a new edition within a year was a far higher testimony to the merits of the book than anything which we could write to commend it, and now with the publication of the seventh edition we feel this all the more strongly. In this issue all the letterpress of the book has been subjected to careful revision, and much new and valuable matter has been added. The new chapters and sections bring the book again abreast of the times. In this edition the following new subjects are incorporated: General Pathology of the Skin, Radiotherapy and Phototherapy, Granulosis rubra nasi, Pyroplasmosis hominis, Erythema elevatum diutinum, Ulcerating Granuloma of the Pudenda, Psoriasiform dermatoses, Acrodermatitis perstans, Dermatitis vegetans, and Acrodermatitis chronica atrophicans. The sections on General Pathology, Radiotherapy and Phototherapy, and the Pathology of cutaneous tuberculosis are from the pen of Dr. O. S. Ormsby, and are carefully written. We think that in the chapter on Radiotherapy the writer might have been more emphatic with regard to the dangers of the X-rays to the operator as well as the patient.

Besides the new sections others have been largely or wholly rewritten—for example, those on Dermatitis exfoliativa, Pityriasis rubra pilaris, Lichen planus, Ichthyosis, Xeroderma pigmentosum, the Dermatoses associated with Tuberculosis, Blastomycosis, Acrodynia, Pellagra, Piedra, and Verruga Peruana. The extra matter and thorough revision of the book has resulted in the production of a treatise on the subject of skin diseases which is one of the most complete and reliable in the English language.

LIST OF BOOKS, PAMPHLETS, ETC., RECEIVED.

From REBMAN, 128, Shaftesbury Avenue, London. *Syphilis and Gonorrhœa*. By C. F. MARSHALL, M.D., F.R.C.S. Price 8s. nett.

Light Energy. By MARGARET A. CLEAVES, M.D. Price 21s. nett.

From ADLARD AND SON, Bartholomew Close, London, E.C. *The Differential Diagnosis of Syphilitic and Non-syphilitic Affections of the Skin*. By GEORGE PERNET. Price 6s. 6d. nett.

From LEA BROTHERS AND CO., Philadelphia and New York. *A Practical Treatise on Diseases of the Skin*. Seventh Edition. By JAMES NEVINS HYDE, A.M., M.D., and FRANK HUGH MONTGOMERY, M.D.

From J. RUEFF, 106, Boulevard Saint Germain, Paris. *De l'Artérite Syphilitique*. By J. DARIER.

From H. K. LEWIS, 136, Gower Street, London. *Medical Electricity*. Fourth Edition. By H. LEWIS JONES, M.A., M.D., F.R.C.P. Price 12s. 6d. nett.

From GUSTAV FISCHER, Jena. *Pneumonomykosis aspergillina*. Dr. FR. SAXER. Price 8 marks 75 pf.

From HENRY KIMPTON, 13, Funnival Street, Holborn, E.C. *A Practical Treatise on Genito-Urinary and Venereal Diseases and Syphilis*. By ROBERT W. TAYLOR, A.M., M.D. Third Edition. Price 28s. nett.

THE BRITISH JOURNAL OF DERMATOLOGY.

FEBRUARY, 1905.

LICHEN PILARIS, SEU SPINULOSUS.

By H. G. ADAMSON, M.D., M.R.C.P.

Physician to the Skin Department, Paddington Green Children's Hospital.

UNDER the above title there is well known, in this country, an affection occurring chiefly in children, perhaps more often in boys, characterised by the appearance of fine projecting filiform spines, arising from pilo-sebaceous follicles, the mouths of which are raised into small, acuminate, pale, or pinkish papules, and arranged in groups or patches on various parts of the limbs and trunk. During the last twenty years some score or so of cases have been exhibited at the meetings of the Dermatological Society of London. It is strange, however, that one finds no reference to this disorder as a definite clinical group in Continental literature. It has been pointed out by Dr. Colcott Fox and by Dr. Radcliffe-Crocker that such cases as those known to us as Lichen spinulosus have been described in France under the name of *Acné cornée*. The correctness of this assertion will be demonstrated when I come to quote some examples from French literature, although it must not be supposed that the term *Acné cornée* is synonymous with *Lichen pilaris, seu spinulosus*, since it certainly includes several other affections. In Germany Unna has given the name of *Keratosis follicularis spinulosa* to this disorder. In his *Histopathology* (Norman Walker's translation, 1896, p. 288), referring to *Lichen spinulosus* of Devergie as described by Dr. Radcliffe-Crocker, he distinguishes it from the *Keratosis pilaris* of Brocq, and gives it this new name. He, however, dismisses it in a few words, and in German literature I know of no other reference to it.

Even in this country a clear distinction is not always made between this and other affections with follicular plugs. Most of the English, and it may be added most of the American, authors seem to regard the term *Lichen pilaris* or *Lichen spinulosus* as synonymous with *Keratosis pilaris*, a confusion which has probably arisen partly from the fact that the more common affection, *Keratosis pilaris*, was originally known as *Lichen pilaris* (Bazin) and partly because *Lichen spinulosus* is a somewhat rare disorder. Stelwagon, for example, states that he has never seen a case, and the short account which he gives as an appendix to his article on *Keratosis pilaris* is quoted verbatim from Dr. Radcliffe-Crocker's book.

This affection, although of somewhat rare occurrence, and perhaps in itself deserving of no great attention, is, however, as one of a large group of follicular keratoses, of considerable interest and importance. The disorder to which the term *Lichen pilaris, seu spinulosus*, is usually applied occurs, as I have already stated, generally in children, and the grouped filiform spines, arising from minute follicular papules, constitute the whole eruption. Exactly similar spines may be seen, however, under other conditions. They may appear in connection with *Lichen scrofulosorum* in rare instances and, not uncommonly, they may occur in conjunction with *Lichen planus*. These relationships will be discussed later, and for the present I shall confine myself to the more typical cases.

HISTORY OF THE AFFECTION IN THIS COUNTRY, WITH A RECORD OF REPORTED CASES.

Attention was first drawn to these cases by the exhibition of two examples, one by Dr. Radcliffe-Crocker and one by Dr. Colcott Fox, at the meeting of the Dermatological Society of London on February 14th, 1883. The Proceedings of the Society were not, however, published in this JOURNAL until 1895, so that these cases have not hitherto been recorded in print. Dr. Colcott Fox has very kindly given me the opportunity of examining the notes made by himself in connection with these earlier meetings of the Society, and from them I extract the following accounts.

DR. RADCLIFFE-CROCKER'S Case.—*Acute Lichen pilaris (spinulosus)* in a boy. Henry B—, aged 6 years. The disease is in irregular patches, from one to several

PLATE I.



TO ILLUSTRATE DR. ADAMSON'S PAPER ON LICHEN PILARIS SEU SPINULOSUS.

inches in diameter, symmetrically arranged. It has been present about five weeks, the patches appearing successively, and having continued to develop up to about a week ago. Each patch comes out rapidly; thus, the patch on the neck was all out in one day, and the rest have come out at intervals in the same way. It came first on the back of the neck, then on the front of the thighs. It is also present on both arms, near the shoulders, and in the axillæ, slightly in the flexures of the elbows and also on the tip of the right elbow. The trunk is free as far as the ilium, the area corresponding with this being thickly covered. It is also present on the front, outer, and posterior surfaces of the thighs, outer side of knee, and in the popliteal spaces, more below the upper two thirds of the tibiæ in front, a few on the sacrum and in the gluteal cleft. Individually the papules are pin-head size, of the same colour as the normal skin for the most part, evidently about a hair-follicle, with a spiny projection of horny epithelium one sixteenth inch in length. In all the most developed papules the hairs have fallen out. In some situations the papules are distinctly red, and there are more in this condition than there were one week ago. The child is pale, moderately well nourished, but is always tired.

Dr COLCOTT FOX's Case.—*Lichen scrofulosus (spinulosus)* in a boy, aged 8 years (Harry R—). Chronic circumscribed patches of miliary acuminate papules (follicular), just below and on the extensor surface of each elbow joint, behind each shoulder joint, over each hip, below each knee joint, on the extensor surface, where it had nearly faded away. A patch has disappeared from the sacral region and from the back of the neck above the collar. The latter patch had little projecting spines. Duration about one year. Patient attended a Children's Hospital for pustular eczema two years ago, and for ringworm of the scalp one year, ago. Has chronic nasal catarrh, some adenitis, and is very pallid and delicate. The mother is also pallid and delicate, and phthisis is marked on her side of the family. Father said to be not strong. Patient had ten brothers and sisters; two died with rickets, one has spinal disease; none were strong.

Note by Dr. COLCOTT FOX.—This case was very similar to the one shown by Dr. Radcliffe-Crocker, and the two elicited much discussion as to a proper name, the presence of itching, etc. The general opinion seem to be that it was an affection distinct from ordinary *Lichen scrofulosus* of Hebra. Dr. Colcott Fox contended that the spines were not pathognomonic. They were a mere complication, and were occasionally seen in other indolent follicular eruptions, even in the miliary syphilide.

On March 14th, 1883, another case was exhibited by Dr. Colcott Fox:

Dr. COLCOTT FOX, Case 78.—*Case for diagnosis* (*Lichen simplex*) in a boy Henry W—, aged 2½ years. The whole trunk, front and back, especially the abdomen, is thickly set with tiny, conical, pinkish, follicular papules, not black-topped. Every follicle is plugged and slightly congested and from some spines project. The mother points to a patch developing on the poll, which raises the suspicion of its connection with *Lichen scrofulosus*. The eruption also reminds one of the follicular miliary eruption so frequently seen on the upper arms of certain children (*Keratosis pilaris*). The eruption is not erythematous and soft like papular eczema, but harsh and file-like. Slight rickets and phlyctenular ulcers leaving corneal opacities. Duration: the mother says it developed in the

night ten days ago, the child being in fair health. There are no indications about the eruption, however, of an acute evolution. It looks essentially a chronic affection.

These two early cases of Dr. Colcott Fox illustrate the difficulty in some examples of diagnosis from Lichen scrofulosus. This difficulty, though less now that Lichen spinulosus is recognised as a clinical entity, may still occur and will be referred to later in discussing the clinical relationships of this affection.

Another case was shown by Dr. Radcliffe-Crocker, on May 14th, 1884:

DR. RADCLIFFE-CROCKER, 226.—*General inflammatory Lichen pilaris* in a lad aged 15 years (Percy C—). On the scapular regions, but not between, over the whole of rest of back, buttocks, trochanteric regions, and upper third of thigh, and on abdomen and lower part of chest. Slightly on arms and legs, both surfaces. In groups on limbs, but evenly distributed on trunk. Consists of acuminate papules, pin's-head size, red, or pale red, with central spiny projections, which could be extracted, and consists of horny cells. Father subject to psoriasis. Patient looks delicate but is fairly healthy.

On October 8th, 1884, a case by

DR. WICKHAM LEGG, 276.—*Lichen (keratosis ?) scrofulosorum, Lichen spinulosus* in a boy. Bristly spines extended from follicles of symmetrical areas on the back of the neck and hips. On the outside of the thighs and arms there is a miliary papular eruption due to indolent follicular inflammation.

On June 10th, 1885:

DR. WICKHAM LEGG, 344.—*Keratosis pilaris spinulosus* in a child aged 6 years—*i.e.* patches on the back of the neck, around the trunk, on the buttocks, etc., composed of aggregated erected follicles from which long spines project. Dr. Radcliffe-Crocker calls it *Keratosis (? pilaris)*, and thinks it is not inflammatory. Mr. Baker and Dr. Liveing consider it distinct from Lichen scrofulosorum.

On July 8th, 1885:

DR. PAYNE, 365.—*Lichen (keratosis) spinosus*. The whole trunk is covered with erected follicles, from which spines protrude. The eruption is, for the most part, not patchy, but uniformly distributed. There are, however, patches. Duration two months. Evolution rather acute.

On March 10, 1886:

MR. MALCOLM MORRIS.—*Lichen pilaris* acutely developed in a man, after scarlet fever. The eruption is reddish in colour, miliary, papular, and follicular. Many lesions show projecting spines. The eruption is limited almost exclusively

to the trunk and extensor surfaces of the upper arms, and is for the most part uniformly distributed and not patchy. A discussion arose as to the appropriate name for these follicular affections, and in attempting a diagnosis, *Keratosis pilaris*, *Lichen pilaris*, and *Lichen scrofulosorum* were passed in review.

This case cannot be regarded as a typical example; it occurred in an adult, and the lesions were not grouped. The record of the case is perhaps insufficient to enable a more definite statement.

Dr. PERRY, 1221.—*A case of Lichen spinulosus*, of 12 months' duration, in a girl aged 7 years.

On April 11, 1894:

Dr. PERRY, 1456.—*Lichen pilaris (spinulosus)* in a boy aged 11 years, of two months' duration. The aggregation of miliary red papules with protruding spines occurred on the back of the neck, the arms, the flanks, and thighs.

On April 11, 1894 (1457):

Dr. SAMUEL WEST.—*Lichen pilaris (spinulosus)* in a boy, aged 8 years. This case was almost the exact counterpart of Dr. Perry's, No. 1456.

Following these earlier cases exhibited at the Dermatological Society was the first published account of this disorder, viz. that by Dr. Radcliffe-Crocker in the first edition of his *Diseases of the Skin*, 1888, and there is no doubt that the general use of the name *Lichen pilaris*, *seu spinulosus* dates from this publication.

We now arrive at the period at which the Society's Proceedings were first published in the JOURNAL. In 1895 Dr. Colcott Fox showed two cases:

Dr. T. C. Fox's case (*British Journal of Dermatology*, vol. vii, 1895, p. 90).—A case of *Lichen pilaris* (Crocker) in a healthy boy aged 7 years. The mother had noticed some roughness over the shoulders three weeks previously, and the next morning distinct patches of eruption on the trunk. The eruption since gradually developed. Present state: On the front of the trunk are a few rounded or oval patches, pink in tint, or hardly coloured, or uncoloured, characterised by a projection of all the follicles under such patches, and the protrusion of a little spine from each follicle. These areas feel rough and file-like to the touch. There is a strong tendency to symmetry in the patches. Similar patches, but much redder in colour, are seen on the back of each shoulder-joint; over the back are numerous patches, with an obvious tendency to arrangement in accordance with the fibrous framework of the skin. Many of the patches here are large and indistinct in outline, and only fully observable in certain side-lights. Over the loins and buttocks, and on the outside of the thighs, the patches are again well-marked. At the root of the toes there is a patch on each foot. There is also a patch just

below the right elbow joint. The external aspect of the arms is rough, but not strikingly so. The follicles generally of the trunk and limbs appear to be prominent, but the skin, apart from the eruption described, cannot be said to be very harsh and dry. There is no itching to speak of, and no evidence of scrofulo-tuberculosis.

Dr. Colcott Fox brought the case as a good example of a somewhat rare child's disease, well known, however, in London. He pointed out that it had to be distinguished from (1) *Keratosis pilaris* of Brocq; (2) true mild ichthyosis (xeroderma), in which the follicles are specially implicated; (3) some uncommon forms of folliculitis to which the terms *Lichen simplex* or *pilaris* had been applied and the exact nature of which was still involved in doubt; (4) *Lichen scrofulosus* of Kaposi. "The formation of spines appeared to be an integral part, as it was a conspicuous feature of the malady; but the exhibitor had pointed out that similar spines may be present in the *Keratosis pilaris* of Brocq, and he had observed one case of the *miliary follicular syphilide* in which they were present."

Dr. Colcott Fox showed a second case at the next meeting (*British Journal of Dermatology*, vol. vii, 1895, p. 152):

The patient was again a boy, aged 7 years, ill-nourished, and of delicate appearance. The case was similar to the last one. The eruption consisted of aggregations of erected and plugged follicles, which had been present about six months. There was a little group of six lesions on the forehead, two symmetrical elongated patches on the outside of each elbow region, a rounded patch on the left buttock, and a symmetrical aggregation on the outside of each calf. The papules were minute, follicular, reddened, rounded with a central plug, which was either comedo-like or spinous. It appeared as if the lesion began by the formation of a tiny plug, and to this succeeded some surrounding congestion.

For comparison, Dr. Fox showed other cases, examples in children of *Ichthyosis follicularis*, true ichthyosis picking out the follicles, of *Keratosis pilaris* of Brocq, and of *Lichen scrofulosorum*.

On February 12th, 1896 (*British Journal of Dermatology*, vol. viii, 1896, p. 98):

Dr. E. C. PERRY presented a case of *Lichen spinulosus* in a boy aged 14 years. On the front and sides of the neck, over the shoulders and arms, and over the axillæ, on the abdomen, and in the groins, and also on the buttocks, back, and interscapular region, there were innumerable small follicular papules, from the summits of which there stood out bristles, about one eighth of an inch in length. The patient stated that he had had it for six months, and that it first started on the arms; it itched very little. The confusion in diagnosis between this condition and *Keratosis pilaris* was remarked on by Dr. Perry and others present.

On July 8th of the same year (*British Journal of Dermatology*, vol. viii, 1896, p. 326) :

Dr. EDWARD MACKEY showed a very beautiful photograph of a case of *Lichen pilaris* (*spinulosus*) affecting the nape of the neck of a girl aged 12 years. It had existed for two years. Similar patches were present along the edges of the axilla and over the ham muscles. The affection had yielded to treatment by the use of frequent baths and the application of alkaline lotions and tar.

On July 30th, 1900 (*British Journal of Dermatology*, vol. xii, p. 297) :

Dr. J. J. PRINGLE exhibited a somewhat aberrant case of *Lichen spinulosus* (*vel pilaris*) in a girl aged 8 years. The eruption was of nearly three months duration, and was undergoing rapid improvement under treatment. It had begun on the legs, where there were typical large plaques, with projecting horny spines, giving a nutmeg-grater-like sensation on palpation. A similar plaque was present over the back of the neck. The peculiarity of the case consisted in the remarkable degree to which the back was affected. The whole of that region was thickly studded with spiny lesions, but they were arranged in very minute corymbose groups of twos and threes, while many were single.

On March 12th, 1902 (*British Journal of Dermatology*, vol. xiv, p. 132) :

Dr. RADCLIFFE-CROCKER showed a case of *Lichen pilaris, seu spinulosus* in a boy aged 6 years, which had been present two weeks. It occupied the neck and upper three quarters of the back. The spines were longest in the neck, mainly projecting one sixteenth of an inch or more, while on the body they diminished in prominence until they were merely convex horny papules. They were so closely set that the appearance of *Lichen acuminatus* was simulated, but neither on the face nor on the palms were there the usual signs of that disease.

To this list must be added the following typical example, published in Australia, and for the reference to which I am indebted to Dr. Colcott Fox :

Case of Lichen spinulosus (Devergie). F. A. BENNETT. (*Australasian Medical Gazette*, December 20th, 1902, p. 615.) The patient was a healthy girl of about 14 years of age. The skin condition developed three months ago during convalescence from influenza. It began on the left side of the neck, which it gradually and entirely encompassed, and then passed on to the face. Later the arms, waist (slightly), buttocks (profusely), hips, and legs were attacked, leaving the hands and feet free. It consisted of a horny papular eruption, strongly imparting a nutmeg-grater-like sensation to the hand, and distributed more or less symmetrically over the areas indicated. In certain places the papules were crowded closely together, though remaining absolutely discrete. No tendency to scaling except slightly on the face, which has a seborrhoeic appearance. On the arms and thighs the lesions run so closely together as to form almost continuous sheets. The lesions are discrete, reddish, conical, pin-head, follicular

papules, from the centre of the majority of which fine horny spines project. These spines are best seen under the chin and on the neck, especially back and front. The spines are sufficiently long to be readily seized between the finger and thumb of the patient and thus removed. The scalp is unaffected, as also the palms and soles and nails. There is little or no itching.

The writer refers to Dr. Radcliffe-Crocker's description of this affection. In regard to the diagnosis of his own case he mentions the features which distinguish it from *Kerutosis pilaris* and from *Pityriasis rubra pilaris*.

To this list of examples must be added another case represented by a model (381) in the Royal College of Surgeons' Museum. The model is No. 544 of Wilson's *Catalogue*, second edition, and is there entitled *Folliculitis setosa*. Dr. Radcliffe-Crocker in the catalogue as revised by himself labels it *Lichen pilaris, seu spinulosus*. Wilson's original description runs as follows :

"Model of the forearm, showing a chronic form of folliculitis accompanied with accumulation of epithelial exuvie within the follicles. The morbid affection occupies the greater part of the surface of the forearm, in some parts resembling *Cutis anserina* without hyperæmia, in others being slightly hyperæmic and studded with black points, the discoloured exuvial product of the follicles, which latter projects beyond the level of the skin. A large, almost circular patch, an inch and a half in diameter, is seen a little above the wrist, and two or three patches of irregular figure higher up the arm." To this description Dr. Radcliffe-Crocker has added: "A typical example of *L. spinulosus*, except that here the filiform spines are not shown, but the slightly raised follicle is shown blocked with a black pin-point horny plug. In more marked instances of this affection, as usually seen on the neck and back, distinct horny spines project about one sixteenth of an inch above the surface."

HISTORY OF FRENCH CASES.

Turning now to the French cases, as I have already stated, several examples have been described in France under the name of *Acné cornée*; since that name has, however, been used for several other follicular eruptions, it will be necessary, first of all, to consider the origin and application of this term.

Biett and Cazenave, at the beginning of last century, described under the name *Acné cornée sébacée* a group of affections in which the prominent feature was the presence of horny plugs in the pilosebaceous follicles. The term for a long time dropped out of use, until it was recently revived by Tenneson and by Hallopeau, who recognise that Cazenave's use of it covered several different types, which have since been more fully described by later observers under

different names. They use the term *Acné cornée* in a more restricted sense, and eliminate from the group the two affections of the follicles now known as *Darier's disease* or *Keratosis follicularis*, and *Brooke's disease* or *Keratosis follicularis contagiosa*. Going back to an earlier period, one finds, however, that Hardy, and afterwards Leloir and Vidal, already restricted the use of the term in a similar way. Hardy, in his '*Leçons sur les Maladies de la Peau*' (Part II, 1859, p. 105), wrote as follows: "This variety of acne (*Acné cornée sebacée*) is still less known than the preceding (*Acné sébacée fluente*). Described for the first time some years ago by M. Cazenave, its history is not yet by any means cleared up. This affection presents itself in the form of yellowish, grey, or black eminences, acuminate, and giving to the touch a sensation of a brush or rasp; on pressing the base of the little tumours, they can be made to project still more; sometimes even they are squeezed out, when the open orifice of the sebaceous follicle becomes visible and shows what was their seat and how they were produced. This change in the follicles may be met with in all regions of the body—on the forehead, on the nose, on the trunk, or on the limbs; and these little tumours, sometimes united in groups and sometimes disseminated, never cause smarting nor itching, and constitute rather an infirmity than a real disease. Their course is very chronic, and the horny secretion may persist for months or years unless the affection is modified by suitable treatment."

Hardy says that the affection is very rare, but that its diagnosis is easy, although it must not be confounded with *Pityriasis pilaris* (*i. e.* *Keratosis pilaris*) nor with a variety of scrofulide which he calls *Scrofulide cornée*, and which from his description seems to correspond to our *Lichen scrofulosorum*.

This description of Hardy's does not, however, correspond in all points with the English cases. There is no mention of the filiform spines which form such a striking feature as a rule; the tendency to grouping, though mentioned, is not emphasised; lesions are said to occur frequently on the face and nose, situations usually unaffected in our cases. Hardy, however, says that it is rare, and distinguishes it from *Pityriasis pilaris* (the old name for *Keratosis pilaris*), and, as will be presently seen, Hallopeau regards the *Acné cornée* of Hardy as the same affection as his own *Acné cornée*.

Guibout (*Maladies de la Peau*, Paris, 1879, p. 662) has referred to

Acné sebacée cornée in generalised terms, distinguishing it from ichthyosis. He refers to long horny spines projecting from the sebaceous glands. He says: "In this form the sebaceous matter, secreted in great abundance, is retained in the excretory ducts of the sebaceous glands; it there hardens and takes on the consistence of a horn. The rounded cylindrical or thread-like form is given to it by the calibre of the excretory canal, in the interior of which it had been retained, hardened, and, so to speak, moulded. In raising itself above the surface of the skin in the form of projections more or less prominent, the sebaceous matter forms so many hard, prickly, and horny points, which give to the hand passed over the surface the dry pricking sensation which it experiences from the skin of a reptile or bird."

The brief description of Leloir and Vidal (*Traité descriptif des Maladies de la Peau, 1^{re} Livraison*, p. 7, 1889) of *Acné cornée* (which they refer to as the *Acné cornée sebacée* of Hardy) is as follows: "Characterised by hard points, projecting beyond the level of the skin, reaching often three or four millimetres in length exceptionally isolated, these asperities are almost always grouped on a circumscribed plaque of rather limited extent, seldom exceeding 2 to 3 centimetres. This plaque is bristling with points rather regularly spaced, yellow, brown or black, giving to the touch the sensation of a rasp. Each of these horny projections is encased by its root in the funnel of the pilo-sebaceous follicle which has given birth to it. On pressing their base they become even more raised, and may even be expelled entire, although they are rather brittle. The orifice of the follicle remains patent after the expulsion of the comedone. This form of acne is met with chiefly upon the skin of the face, of the posterior cervical region, on that of the back and of the buttocks, and it may remain for many months or years without provoking perifollicular inflammation."

This account of Leloir and Vidal, in spite of the fact that they give the face as one of the usual seats of the eruption, must, I think, be regarded as referring to cases of the same type as our *Lichen spinulosus*.

Besnier in the French translation of *Kaposi* (2nd edit., t. i, p. 785) refers to the *Acnée sebacée cornée* of Cazenave and Hardy, and the *Acnée cornée* of Leloir and Vidal, and re-christens them with the name

Angio-folliculite (folliculite canaliculaire) *kératosique simple*. He applies this name to an acne with horny comedones, destitute of any known parasite, often abortive, unperceived, ignored, disposed in disseminate îlots in parts of election, among them the neck, the back, etc., usually torpid and having no other result than the atrophy of the follicle. He adds that many observations reported are ambiguous and contestable, but that their differentiation will, in the future, be established by the aid of histological and bacterial control, and that "angio-folliculite cornée" will no longer be liable to be confounded with ichthyosis, pilar xerodermia, erythematous or not, pityriasis pilaris, acneiform lupus.

As has already been stated, the term *Acné cornée* for long dropped out of use, and with the exception of this description by Leloir and Vidal, and the reference to it by Besnier, I am unable to find any mention of it until it was again revived by Tenneson and by Hallopeau in 1895. In that year several cases were shown by these observers at the meetings of the Société Française (published in the *Annales*, vol. vi, 1895, p. 285), which recalled to them the descriptions of *Acné cornée* of Hardy and of Leloir and Vidal. Tenneson's case, which he called *Acné kératique*, appears, however, to have been a unique affection, and although classed by Hallopeau along with his own cases, it was not regarded by Tenneson himself as the *Acné cornée* of Leloir and Vidal, nor as of the same nature as Hallopeau's cases. "The patient was a man, aged 26 years, and presented on the back, shoulders, chest and face the various lesions of *Acne vulgaris*, and besides these there were on the trunk and face, principally on the posterior part of the shoulders, little horny elevations, grouped in large numbers, in vast areas of polycyclical outline. They resembled *Keratosis pilaris* to the naked eye, but there was no *Keratosis pilaris* in the usual situations" (photographie aquarellée des lésions par Méheux, au Musée de l'Hôpital St. Louis, Dessins, No. 309). The microscope showed it to be a distinctly inflammatory affection, with much cellular exudation.*

* Leredde made a histological examination in this case, and found an invasion of the sebaceous glands by inflammatory cells, with some cellular exudation also around the hair-follicle, and at the mouth of the follicle a crateriform fossa with irregularly stratified horny borders, the cavity being occupied by a necrosed hair, surrounded by horny lamellæ. Tenneson regarded it as a modified acne often seen in a less marked form. He says it is not the *Acné cornée* of Leloir and Vidal

While this is certainly not a case of *Lichen spinulosus*, the examples shown by Hallopeau, although differing in some particulars, and in the comparatively advanced age of the patients, are much more probably of this group. A case shown later in the same year by Hallopeau in a girl, aged 11 years, and called by him *Acné cornée en aires*, is certainly a typical example.

HALLOPEAU and JEANSELME. *Acné cornée*. CASE 1.—(*Annales*, tome vi, 1895, No. 3, p. 306). Anna B—, aged 25 years. Eruption present five months. Lesions grouped, and consisted of comedones which in places were filiform, black, and measuring several millimetres in length. There were groups of three or four, and twenty, or in numbers too large to count. They are situate on the posterior border of the axillæ, the elbows, the dorsal surface of the limbs, the postero-external regions of the forearms and thighs. In some parts the changes were less pronounced, and there was only a shagreened condition of the skin, giving a sensation of roughness to the hand; this was so at the back of the neck. The follicular elevations were very pronounced on the lower limbs; they there attained the dimensions of a large millet-seed. The parts affected were at night the seat of an intense pruritus. The general health was good. The eruption rapidly progressed, and became almost generalised upon the forearms, although healthy areas of skin could here be distinguished. The eruption was symmetrical. The face escaped.

CASE 2.—Marie T—, aged 24 years. Vigorous constitution. Eruption present some years. On the lower part of the dorso-lumbar region, on each side of the vertebral column, numerous comedones occupying a surface of the extent of the hand; each plaque extended a little over the iliac crest and to within 4 cm. of the spine. The number of sebaceous glands involved reached several hundreds. Each comedone, of a dark brown or black, dilated the glandular orifice, raising it slightly, and projecting from it from half to one or even two millimetres. If one of these little concretions were enucleated by pressure, which was very easily done, a sort of horny pearl was obtained, almost translucent, which slid and escaped like the stone of a cherry, when one tried to crush it between two glass slides. Its deep extremity was more soft and white, and had depending from it a glabrous hair. Between the comedones were disseminated numerous superficial, whitened, circular cicatrices, measuring about 5 mm. in diameter, slightly raised at their periphery, and lightly depressed at their centre, from which a hair emerged. They are consecutive to suppurations, which, the patient says, return every year: the pigmented spots are of the same origin.

There were a few groups of comedones on the front of the waist and below the umbilicus. There were a few erratic comedones on the conchæ of the ears, the axillæ, the groins, the pubis, the thighs, and the legs. On the dorsal surface of the arms there is a keratosis pilaris. Rapid improvement took place under treatment by sulphur ointment; the greater number of the comedones were eliminated, leaving the dilated orifices of the pilo-sebaceous follicles surrounded for the most part by white and pigmented elevations.

or of Hardy, nor is it the *Acné cornée* of model No. 1781 in Museum St. Louis deposited there by Hallopeau.

CASE 3.—George B—, aged 36 years, in good health, no acne vulgaris; on lower part of back filiform comedones, blackish in colour, about one millimetre long; they are not grouped: they are on each side above the posterior part of the iliac crest; in front of the trunk are a few erratic filaments: the pilosebaceous follicles are slightly raised around these concretions.

These cases were in adults, which is unusual, and the description of the individual lesions does not quite suggest those of Lichen spinulosus. Hallopeau's fourth case, already referred to (*Acné cornée en aires*) (*Annales*, vol. vi, 1895, p. 1141), is a quite typical example of Lichen spinulosus of childhood.

This patient was a little girl (Alice K—) aged 11 years. One year ago there had been noticed on the left arm a group of small elevations, with blackened summits, and hard to the touch. In hospital there was found also upon the upper and external part of the left arm, near the deltoid insertion, a 50-centime-piece-sized group of tiny elevations, acuminate, and surmounted by a hard comedo, horny, fine, thread-like (*effilé*) and black, $\frac{1}{2}$ –1 mm. long, and enucleable. They were on a base slightly reddened, but without any thickening. Close around were a few less noticeable non-pigmented elements below and towards the lower half of the arm; on the external surface there was a plaque 5 cm. by 3 cm., having a reddened base, the redness not disappearing easily on pressure: on the external surface of the forearm a group of 4 cm. by 2 cm. and below this a group of a dozen lesions. There were several less accentuated groups in the lumbar region and on the neck, below the sterno-clavicular articulation, several elevations, rough to the touch, white at their extremity, and not lying on a red base. There was no pruritus nor pain. Rapid amelioration in hospital with alkaline baths and boric ointment.

In spite, however, of this revival of the interest in the group of *Acné cornée*, no similar examples appear to have been shown at the Paris Society since the date of the exhibition of these cases. Thibierge, in the article "*Acné cornée*" in *La Pratique Dermatologique*, divides those affections which he says are still entitled to be included under this term into two distinct types. The first, the most simple form, is that of Hardy and Leloir and Vidal, whose descriptions he quotes. The second type he calls *Acné cornée exanthématique*. He says that this type is most often seen in young subjects, and that it often coincides with seborrhœa. He appears to base his description chiefly upon the case of *Acné kératique* of Tenneson, which he mentions as an example of this type, and of which he quotes Leredde's histopathological description. He says, moreover, that the cases described by Brooke (*Keratosis follicularis contagiosa*) are allied in some respects to this group of *Acné cornée*. He makes

no direct reference to the cases of Hallopeau which were demonstrated to the Société Française at about the same time as was Tenneson's case.

It will be seen, then, that although the use of the title *Acné cornée* has become more restricted since it was first used by Bielt and by Cazenave, yet there is still some confusion as to the exact application of the term.

The following case will show the difficulty in coming to a definite conclusion as to the identity of Hallopeau's cases with those of our *Lichen spinulosus* :

In 1901 in France, Baudouin and Du Castel showed "a case of *Kératose folliculaire villoseuse*," which Barbe thought was Brooke's disease.

DU CASTEL and BAUDOUIN'S Case (*Annales*, 1901, p. 422).—Male, aged 20 years ; since two months ago there has developed upon various parts of the body a granular condition made up of little red papular elevations, from which arise horny, villous prolongations about one millimetre long. The morbid plaques occupy especially the hips, the posterior part of the arms and of the forearms, the shoulders, below the chin and the upper and anterior part of the neck. The eruption is indolent. The patient has an old, well-marked *Keratosis pilaris*. General health excellent. Histological examination showed a keratosis of pilar origin, with slight leucocytic infiltration around the follicles.

Now, this condition of indolent papules with fine horny spines in patches above the trunk and limbs recalls exactly our *Lichen spinulosus*. Hallopeau, however, said that it had neither the characters of *Keratosis pilaris* nor of *Acné cornée* ! M. Barbe thought it Brooke's disease (*Keratosis follicularis contagiosa*).

Then, again, at the following meeting of the Société Française M. Barbe showed the two cases recorded below as examples of Brooke's disease. He, however, thought that they were like Leloir and Vidal's and Cazenave's *Acné cornée* ; he said they were not the *Acné kératique* of Tenneson. There can be little doubt that they were examples of our *Lichen spinulosus*, although it is not reported that Hallopeau claimed them as his *Acné cornée*.

M. BARBE. *Kératose folliculaire (type de Brooke)* (*Annales*, 1901, p. 535).—Two brothers. E. B—, boy, aged 7½ years ; manifestations of hereditary syphilis. For three months, upon the nape of the neck, on the lateral parts of the neck, and even on the anterior surface of this region were little elevations like tiny spines, from one to two millimetres in length, greyish-yellow in colour, dis-

seminated over these regions, giving the sensation of a rasp. These elevations emerge directly from the follicles and are not implanted upon little raised papules, as in the case of Du Castel and Baudonin, possibly because at an early stage. The spines can be pulled out like a trichophyton hair, short and broken. No psorosperm bodies nor micro-organisms in the plug.

Paul, the brother, aged 8½ years, had exactly the same little spines on the nape. He also had evidences of hereditary syphilis. The eruption went away with anti-syphilitic treatment, and returned when it was discontinued, but this was probably only a coincidence or pointed to its parasitic nature.

Again, quite recently, Professor Audry has published the account of a case of *Kératose pilaire engainante* ("Hyperkératose Circum-pilaire") in the *Journal des Maladies Cutanées* (July, 1904), which I think is undoubtedly an example of our Lichen spinulosus. It is a remarkable circumstance that Audry does not here refer to Hallopeau's cases of Acné cornée, and that he states that he believes the case to be unique. He, moreover, says that he does not think that it corresponds to the descriptions of Lichen spinulosus, statements which seem to show that neither such cases as those described by Hallopeau nor our cases of Lichen spinulosus are familiar to French writers. Audry's case was as follows :

The patient is a boy, aged 8 years, well-developed. The eruption was first noticed about six months ago. It began upon the neck, where the eruption is now best marked. Here the skin is entirely covered with little elevations of an unusual character. They are like minute dry horns, of a pale yellow colour, disseminated on an absolutely healthy skin, each horn corresponding to a hair-follicle. They measure one or two millimetres in length. To the touch the whole area gives the sensation of the chin of a man unshaven for a week. All the follicles are capped with little horns, and look like a patch of grass. The lesion extends from the hair to the seventh cervical vertebra, and laterally on the sides of the neck, below the maxillary angles. On the postero-lateral parts of the neck the disease is more recent. The elements are here formed by little white pilar grains exactly like those of Keratosis pilaris, but they are traversed at their summit by the white and brilliant extremity of a little blonde hair. No pain nor itching. Two or three of the follicles thus modified are surrounded by a little light inflammation and show a minute pustule. But in general the skin is absolutely healthy. The lateral parts of the thorax and of the abdomen present a certain number of grains of Keratosis pilaris exactly like the ordinary type. Nothing on the limbs. Cured in six weeks by oil of cade and an ointment of tar.

There is a description of the histological appearances, which will be referred to under the head of "Pathology."

There is one other case recorded by Giovannini in Italy ("Reperto Istologico in un Caso di Acne Cornea," *Gazzetta Medica di Torino*,

1899, p. 41), which I here quote from an abstract in the *Annales de Dermatologie*, 1901.

The patient was a little girl aged 11 years. There had appeared upon different parts of the body, especially on the neck, elbows, shoulders, back, knees, and legs, very small horny cones apparently arising from the hair-follicles. These cones, which did not give any trouble, had a great tendency to unite in groups and to form plaques of variable extent. They were especially numerous on the neck. The eruption had developed rapidly, lasted about six months, and then disappeared without leaving any trace.

Giovannini's account of the histology in his case will be noticed later.

In conclusion, then, as examples of *Lichen spinulosus* to be found in French literature, I would quote the following :

1. Possibly the *Acné cornée* of Hardy.
2. Certainly the *Acné cornée* of Guibout and of Leloir and Vidal.
3. The case of *Acné cornée en aires* of Hallopeau, possibly his three cases of *Acné cornée* in adults.
4. Barbe's cases of *Kératose folliculaire* (type de Brooke).
5. Audry's case of *Kératose pileaire engainante*. And in Italy—
6. Giovannini's case of *Acné cornea*.

(To be continued.)

SOCIETY INTELLIGENCE.

THE DERMATOLOGICAL SOCIETY OF LONDON.

A MEETING of the above Society was held on Wednesday, January 11th, 1905, Mr. MALCOLM MORRIS in the chair.

The following cases and specimens were demonstrated :

Dr. SALE BARKER (introduced) showed :

(1) A boy, aged 5 years, who came to the Westminster Hospital, with an isolated patch of *Ringworm* over the right parietal bone. The healthy part of the head was protected with lead foil, and X-rays were applied through an opening which allowed a margin round the diseased spot of about three quarters of an inch. Each exposure

lasted twenty minutes, one milliamperè passing through the tube and the spark gap being two and three quarter inches. Ung. hyd. ammon. dil. was prescribed. This was on November 2nd. The hair commenced to fall after the third treatment. On exhibition the exposed patch was smooth, bald, and showed no inflammation.

(2) A boy, aged 7 years, who came up on July 14th, 1904, with *Ringworm* covering the top and back of the scalp and a history of three years' duration. X-rays were applied in exposures of five minutes, the spark gap being three inches. After ten exposures the hair commenced to fall. On October 17th the hair above the ears was found to be infected, so X-rays were applied in exposures of ten minutes; the hair commenced to fall after six treatments. On this date the growth of new hair on the top and back of the head was apparent. On exhibition the places first exposed were covered with healthy hair.

(3) A girl, aged 4 years, who came to the Westminster Hospital on October 20th, 1904, with *Ringworm* covering the scalp, and a history of five months' duration. X-rays were applied all over scalp in exposures of five minutes, with one milliamperè passing through the tube and a spark gap of two and three quarter inches. On November 10th after ten treatments the hair was found to be falling out, and a fortnight later on November 25th the head was completely denuded of hair. On exhibition the scalp was still bald.

MR. WILLMOTT EVANS showed a case which he considered to be a mild form of *Pityriasis rubra pilaris*, but most of those present thought it was certainly a case of *Lichen spinulosus*. The patient was a woman aged 46 years, and for six months she had suffered from a roughness of the skin of the greater part of the body, but especially of the back and loins, where keratinous plugs filled the hair-follicles and projected from them as prominent spines. The backs of the hands were unaffected. The patient had been in bad health during the time the skin lesion had existed, and she had some joints affected with osteo-arthritis. Mr. Evans considered of interest from an etiological point of view the fact that a daughter and a nephew of the patient were both affected with ichthyosis.

DR. COLCOTT FOX presented a man aged 32 years for diagnosis with *congestive patches undergoing atrophy*. The patient, as an engineer,

had been in many tropical countries and suffered from malaria, but was otherwise apparently of sound constitution and born of a healthy stock. He had lived for nearly seven years in Lower Bengal until he became very ill with malaria and enlarged spleen, for which he was invalided home in March, 1903. Since then he had improved greatly in health. His last attack of malaria was in July, 1904.

The eruption appeared about four years before on the lower third of the outside of the right leg, and was described as evolving as a scurfy patch the size of a two-shilling piece, which disappeared and recurred. Then a second patch evolved near it about two years ago, and the two had become confluent. They were of rounded contour. Since June two other patches had appeared on this shin, one above the other. The upper one was oval, four by three inches, with the long diameter in the axis of the leg, and the lower more rounded, two by two and a quarter inches. All the patches were slowly spreading. All presented the same indolent congestive margin with a delicate, superficial nacreous atrophy of the centre. The patches were somewhat dirty-looking and rough with adherent scales, perhaps from treatment. They itched.

On the outside of the lower third of the left leg was a smaller patch of a similar character, said to be of six weeks' duration. Lastly, there was a reddish-yellow rough macule about the size of a shilling just above the elbow on the inner side of the arm, which closely resembled a patch of Eczema seborrhoicum.

Dr. Fox said that in the artificial light available at the meeting he was afraid the members might not be impressed with the existence of the atrophy, which had struck him as such a special feature of the older patches. He had made a careful examination for any signs of lepra, but had failed to find any. The patches were not anæsthetic. There was no sign of any Lupus erythematosus on the sites of predilection of that disease. There was no suspicion of syphilis. He had never observed any atrophy supervening in patches of Eczema seborrhoicum, not even in the inveterate tawny red patches which had attracted attention in recent years and so closely simulated in aspect pityriasis or Eczema seborrhoicum. Nevertheless, the members of the Society were familiar with atrophy accompanying telangiectatic and other chronic states about the face. The exhibitor thought it possible that this case was an example of erythromelie or one of the

similar conditions which authors had described in recent years under similar names. He hoped to be able to report further on the case at some subsequent date. So far the patches appeared to be intractable to treatment, but of this he could not speak from personal experience.

Dr. JAMES GALLOWAY showed a specimen and microscopic section of *melanotic tumour* recently removed.

The patient in whom the tumour occurred was a man of about 50 years of age. He first consulted Mr. F. A. Farr, who, noting the peculiar characters of the tumour, sent him to Dr. Galloway for his opinion. He then presented a tumour, about the size of a small walnut of irregular nodulated shape, of the skin on the front of the right leg. It was coal-black in colour, rising sharply from the surrounding skin, which was normal in appearance, with the exception of an exceedingly narrow border, not more than a millimetre in extent, of brownish pigmentation.

The history of this tumour given by the patient was to the effect that two years previously he had noticed a small nodule, black from the outset, arising from the skin. In the intervening time it had slowly grown to the size of a walnut. On cross-examining the patient, he admitted that he felt certain that previous to the origin of the actual tumour a small black spot had existed in the same situation as long as he could remember. It was not appreciably raised above the surface, and as it had given no trouble of any kind he had paid little attention to it and could not definitely state when he first observed it. Indeed, if it had not been for the gradual increase in mass of the growth he would have probably not sought medical advice, as he suffered no pain and little inconvenience. The patient was in good health. There was no enlargement of the popliteal or the femoral lymphatic glands, or evidence of abnormal pigmentation elsewhere.

From the clinical features presented by the tumour it was decided to remove it freely by excision, and the operation was performed successfully by Mr. H. F. Waterhouse.

Careful examination at the time of the operation failed to reveal any similar growths near the original tumour nor of lymphatic gland enlargement.

Microscopic sections have now been prepared by Dr. J. M. H. MacLeod and show the following characteristics:

The epidermis over the tumour, though thin, is uninterrupted, and shows no sign of malignant proliferation. There is in places an irregular infolding of the epidermis, but this seems to be due more to the irregular surface of the tumour than to a definite downgrowth. A large amount of melanin is contained in the lower part of the epidermis, in the underlying cutis, and throughout the tumour. The main mass of the tumour consists of columns of irregular cuboidal cells presenting epithelial characters surrounded by strands of fibrous tissue. These columns are easily distinguishable, are more or less regular in their arrangement, and contain much melanin. The tumour seems to be definitely localised and has not spread with an indefinite margin into the surrounding tissue. There can be no doubt, therefore, that the tumour has been caused by the growth of these columns of cells in the cutis and that the epidermic cells have taken no part in the increase in size.

The question arises, therefore, whether this tumour is of the extremely malignant character so frequently observed in melanotic growths or not. It will have been noted that there existed a small spot of pigment for many years preceding the origin of the tumour, and that the tumour itself existed two years before removal.

Dr. Galloway wished to point out that in such cases the degree of malignancy of tumours, even of carcinomatous type such as the one under discussion, varied greatly, and that in some cases, even when deeply pigmented, definite malignant changes seemed to be of slow development. He would refer those interested to Dr. Whitfield's paper in the *British Journal of Dermatology*, August, 1900; to various reports by Mr. Jonathan Hutchinson, senior, on pigmentary patches and pigmentary growths, e.g. "The Melanotic Whitlow" in his *Archives of Surgery*, and to a paper by himself in the *British Medical Journal*, 1897.

Dr. Whitfield in his paper specially mentions the comparative non-malignancy of certain melanotic epithelial tumours and suggests histological criteria for the differentiation of these from the melanotic tumours which possess markedly malignant characters.

Dr. GRAHAM LITTLE showed a case of *Lupus erythematosus* in a man aged about 35 years, who had had the disease for six years. It had commenced apparently as the result of a slight superficial abrasion on the

nose, from which the disease had spread slowly. There were patches of rather unusually infiltrated type on the cheeks and nose, with a more superficial involvement of the ear, both the pinna and concha; the aspect of the infiltrated patches suggested the possibility of the existence of a type of disease such as the *Lupus erythematoïdes* of Leloir, and a section of the skin was obtained from a portion of such a patch. It showed nodular cell-collections, very like the foci present in *Lupus vulgaris*, situated in the deeper parts of the corium: these accumulations were, however, centred round dilated blood-vessels, and as Dr. Whitfield pointed out there was no central degeneration such as would certainly be present in the case of tubercular foci of the same volume. No giant-cells were seen either in these cell collections, and the histological appearances, therefore, were on the whole not incompatible with the diagnosis of *Lupus erythematosus* as against *Lupus vulgaris*. It was rather strange that with so extensive an occupation of the face the scalp remained perfectly unaffected by the disease. There was no reaction to a test inoculation of tuberculin. The urine was free from albumen.

Dr. J. M. H. MacLEOD showed:

(1) A case of *multiple Lupus vulgaris following measles*. The patient was a delicate looking girl, aged 3 years. She was the second of a family of three. The elder child was healthy, but the mother said that the baby was delicate and described lesions which suggested "scrofulous gummata." Both the father and mother were healthy, and there was no history of phthisis.

Fifteen months before the case came under observation the child developed measles, and a month later the mother noticed a number of small brown patches which came simultaneously. These had persisted ever since, had gradually increased in size, and on observation proved to be small lesions of tuberculosis cutis. At the time of exhibition the following lesions were present: On the left leg below the knee there was a raised, crusted, and slightly verrucose patch, about the size of a sixpence and of a brownish purple colour. Below that there was a scar of about the same size. About the knee there were several circumscribed patches of lupus, two of which were as large as a shilling. They were ordinary patches of verrucose lupus, but were more purple in colour than was usual. On the left hand there were four verrucose

patches of lupus which were situated about the skin over the proximal phalanges. On the right hand and arm there were six similar patches, and there was a small patch of *Lupus nodularis* on the neck. Besides these patches of *Lupus vulgaris* there were several of the so-called "scrofulous gummata" in different stages of evolution. There was no local or general adenitis, but there were other external signs of tuberculosis, for instance, a fluctuating swelling about the size of a pigeon's egg on the right calf, which was of the nature of what used to be called a "cold abscess." No definite internal evidence of tuberculosis was detected, but the child was a weakling, had a tendency to rickets, and a feeble peripheral circulation with cold sweating feet.

The case was interesting owing to the rapidity with which the lesions of *Lupus vulgaris* had developed after the measles, and their association with other evidences of tuberculosis. Several of these cases had been shown to the Society, and Dr. H. G. Adamson had recently collected a number of them and emphasised their connection with measles (*British Journal of Dermatology*, October, 1904, p. 366).

They were evidently examples of what had been called the "haematogenous origin" of lupus, and the source of infection was probably an infected bronchial gland which had broken down from the measles and infected the blood with tubercle bacilli. In the case of the "scrofulous gummata" the bacilli appeared to stop in the more stagnant veins and there set up an endophlebitis and surrounding infiltration which ended in necrosis. In the case of the multiple *Lupus vulgaris* the bacilli became deposited in the skin capillaries.

(2) A case of actively spreading *Lupus erythematosus* in a married woman, aged 48 years. The disease began last April, and previous to that time her skin had been healthy with the exception of an attack of varicose dermatitis of the right leg, which had disappeared some time before. In November, 1903, the patient was admitted to Charing Cross Hospital for an uterine operation. She was an in-patient for six weeks, and after returning home was confined to bed for a month and to her house till February. Two months later the *Lupus erythematosus* began and it had been steadily growing ever since. At the time of exhibition there were two large symmetrical scaly patches on the sides of the face. The one on the right side involved the ear and extended up on the forehead and down over the cheek to the angle of the jaw. The patch was reddish pink in tinge, and the border was defined and

slightly raised. The patch on the left side of the face was similar in shape and site, but slightly smaller. The scalp was almost universally affected, but the hairs had not come out yet, but were rapidly doing so, and there was a slight indication of the cribriform pitting or scarring which was frequently noted in this affection.

(3) Specimens of *knotted hair from a Cingalese girl*. The exhibitor was indebted to his colleague Mr. Cantlie for the hairs. The patient had had pneumonia seven years before, and since then the hair had never grown properly, had lost its elasticity, and nearly every hair was knotted. There was no sign of deposit on the hair such as occurred in leptothrix and tinea nodosa, and an examination for micro-organisms and fungus gave negative results.

Mr. MALCOLM MORRIS showed: (1) A young lady who had been treated for warts on the backs of both hands by X-rays three years before. Slight burning had taken place and the warts had disappeared, but a year after the cessation of the treatment there had begun the gradual development of telangiectases over the areas which had been exposed, and the process was progressively increasing. The exhibitor drew attention to the long period of quiescence between the end of the treatment and the beginning of the vascular dilatation.

(2) A case of *bullous disease* in an elderly lady. The disease had begun a few months before, and the characteristic lesion was the appearance of flat flaccid bullæ scattered over the body and in the mouth. The general health was fair, and the intervening skin was well nourished and apparently quite sound, but the exhibitor took the view that the case was an early one of Pemphigus foliaceus, a diagnosis with which the majority of the members did not feel inclined to agree.

Sir COOPER PERRY and Mr. GERALD SICHEL (introduced) showed *a case for diagnosis*. The patient was a boy aged 8 years, who had presented himself at Guy's Hospital on January 3rd, 1905. He was suffering from a papular rash affecting sparsely the extensor surfaces of both hands and feet, and the right anterior surface of the abdomen; the spots on the hands and feet were said to have begun about two weeks previously, and those on the abdomen only that very morning.

The papules in the most recent patches were about the size of match heads, circular, well raised and shiny, of a somewhat dusky

pink, and surrounded by a narrow halo of brighter erythema. In the older patches the papules or nodules were slightly larger, flatter, and paler; but purple rather than pink. The tendency to the formation of circular patches was well marked, especially on the hands, where the centres, surrounded by the papules, were clear but rough. There was no marked scaliness.

As regards his previous history, he had measles four years ago, and "rheumatism" twice before that, the last attack followed by "inflammation of the kidneys"; his mother also stated that he had had a similar rash to the present, which went away. His father and mother were alive and healthy, and he had one brother and one sister both alive and healthy. The patient himself was pale, but well nourished.

There was no cardiac bruit, but the heart sounds were not quite as clear as they should be.

On January 5th it was noticed that a fresh patch had appeared in the right lumbar region; there was also noted a small ring-shaped, bruise-like stain just to the left of the middle line on the lumbar spine. In several places on the face and under the chin there were small, rough, slightly raised, well-defined patches of a pinkish colour (as these disappeared without further development, they probably were due to some unimportant cause such as soap-dermatitis).

On January 6th his urine was tested: Acid, sp. gr. 1024; no albumen or sugar.

On January 9th he was suffering from a "cold," and so did not come up to the hospital, as it was wet.

On January 10th he was found to be suffering from chronically enlarged, slightly inflamed tonsils. Urine faintly alkaline, sp. gr. 1016; no albumen or sugar; phosphates came down on boiling.

Sir Cooper Perry was inclined to think the case was one of Erythema elevatum diutinum as described by Dr. Radcliffe-Crocker. He thought, moreover, it was somewhat akin to those subcutaneous rheumatic nodules which are sometimes met with in rheumatic children.

Drs. RADCLIFFE-CROCKER, COLCOTT FOX, and PRINGLE, however, thought that the rash on the abdomen was a Herpes zoster, either badly developed or in the course of evolution, and that the nodules on the hands and feet were Granuloma annulare.

Dr. SEQUEIRA showed a man, aged 58 years, suffering from *Lichen planus annularis*. The eruption first appeared on the front of the wrists two years and a half before. On exhibition the forearms, legs, and thighs were affected, and recently the gluteal cleft had been involved. The eruption was of three forms. On the forearms and thighs there were small purplish rings from one-third to half an inch in diameter. The rings consisted of smooth flat-topped papules; the centre was cicatricial, pale and smooth, and slightly depressed. In other parts the rings were larger and were formed by ringed rows of typical *Lichen planus* papules. In the gluteal cleft the eruption was of the common type. There were a few white spots on the faucial mucous membrane near the last molar teeth on each side.

The eruption had proved very refractory to treatment. Itching was marked in the early stage, and still caused much discomfort in the gluteal cleft.

Dr. F. PARKES WEBER showed a Jewish girl, aged 15 years, with a granuloma-like eruption following the use of bromides for hysterical symptoms. The scalp, the most affected part of the body, was covered with raised patches, some of them extensive, of a kind of granulation tissue tending to become covered with crusts of dried discharge. There were elevated mostly circular plaques of various sizes on the face and extremities, but only one quite on the trunk. Some of these discharged, but others were dry, and one or two had a pitted or honey-combed appearance, seeming to be quite chronic. The patient was somewhat anæmic but otherwise fairly well nourished. There was no evidence of disease of the thoracic or abdominal viscera. The urine was free from albumen. Blood (January 1st): Red cells 3,900,000 per c.mm. of blood; white cells, 12,400; hæmoglobin, 75 per cent. of the normal. There were depressed scars from old tuberculous bone disease on both feet. The eruption began to appear about December 12th, 1904, four days or so after the commencement of the bromide treatment. The total amount taken was only $37\frac{1}{2}$ grains of mixed bromides daily. Dr. Weber first saw the patient on December 22nd, when she had what appeared to be a typical bromide eruption of the granuloma-like or "mycotic" type. The bromides were stopped, but the eruption continued to get worse (possibly the eruption was temporarily increased by painting some enlarged lymphatic

glands in the neck with iodine), and from the appearance of some of the outgrowths Dr. Weber was inclined to think that a kind of scrofuloderma might have been started by the drug, since there was undoubted evidence of previous tuberculous disease in the patient. Anyhow he would regard a scrofulous diathesis as the predisposing cause in the present case for such a severe eruption following only moderate doses of bromides. [Owing to the decided improvement in the eruption afterwards Dr. Weber entirely gives up the idea of the eruption being in any way a scrofuloderma.]

THE X-RAY TREATMENT OF RINGWORM OF THE SCALP.

THE value of the X-rays in the treatment of ringworm of the scalp has now been established. By means of them not only can ringworm be successfully treated, but the time occupied in the treatment of the average case can be reduced to about one quarter of that taken by any other method. Within the last few years, a number of intractable affections of the skin have been found to be amenable to various physical agents. Lupus vulgaris can be destroyed and replaced by a satisfactory scar by Finsen light, and the extensive and dreadfully disfiguring cases which have up to now been so familiar will be practically unknown in future; rodent ulcer has been found to respond readily to treatment by X-rays and radium, and excellent results have been recorded; and now with the discovery that the X-rays can cure ringworm, a mode of treatment has been furnished which will render this disease, the treatment of which has been almost an opprobrium to dermatologists, a more tractable affection. It is a fitting sequel to the brilliant work of Sabouraud in establishing the plurality of the fungi of ringworm, that it should be to him also that we are indebted for placing the X-ray treatment of *Tinea tonsurans* on a sound basis. As far back as 1896 Freund suggested this method of treatment, and it has been tried by a number of observers since then, but whether it was owing to the method being at fault, or to a certain timidity of employing the treatment thoroughly enough from the fear of causing a dermatitis, and of producing a permanent alopecia, it is only com-

paratively recently that the rays have been extensively employed in this connection. In July, 1904, Bunch contributed in this JOURNAL a paper on "Sabouraud's Treatment of Ringworm by the X-rays at the Saint-Louis Hospital, Paris," and in this issue there is an abstract by W. S. Fox of a paper by Sabouraud and Noiré on the subject, and also in the transactions of the January meeting of the Dermatological Society of London there is a report of a series of cases of ringworm treated by X-rays by Dr. Sale Barker at Westminster Hospital.

The principle of the treatment is simply the depilation of the affected areas by means of the X-rays, and not the destruction of the fungus by the rays, as repeated experiment has shown that the X-rays are neither bactericidal nor do they kill the ringworm fungi, and cultivations can be made from affected hairs which have been caused to fall out by the rays. Until lately most workers were in the habit of producing the defluvium by repeated short exposures of five to ten minutes to the rays with the scalp at a considerable distance from the anticathode of the X-ray tube. By this procedure it was sometimes necessary to give fifteen or twenty exposures to cause the defluvium. It is now recognised, however, that the hair may be made to fall out by a single or a couple of exposures without producing a dermatitis. To do this satisfactorily it is necessary that the dosage of the rays should be accurately measured, the quality kept as uniform as possible, and that cognisance should be taken of the condition of the atmosphere at the time of the exposure, as the rays act more rapidly when the air is dry. The dosage in quantity of the rays can be measured by means of a D'Arsonval milliampère metre inserted in the secondary circuit. A regulating tube should be employed, and the spark gap kept at about three inches. Sabouraud estimates the time of exposure requisite to produce a defluvium at one sitting with the exposed area at a distance of six inches from the anticathode by means of radiometer pastilles composed of platino-barium cyanide, which alter their tint on exposure to the rays. One of these is placed on a metal plate at a distance of four inches from the anticathode, and the time taken to change the colour of the pastille from the natural yellowish green of the salt to a standard tint of fawn is the time required under similar conditions of current, tube and atmosphere to produce the defluvium. The hair is first cropped short, and the diseased patches are exposed *seriatim* for the requisite time.

In severe cases it may be necessary to render the scalp completely bald. After the exposures the scalp is washed daily, and an antiseptic ointment is rubbed in all over it to prevent the spread of infection. Sabourand employs an ointment containing oil of cade, and, after washing, treats the whole scalp with an alcoholic lotion containing tincture of iodine. An ointment containing salicylic acid and sulphur or ammoniated mercury may be substituted for the oil of cade ointment where there is any sign of impetigo. The hairs should begin to fall out on the fifteenth day after the exposure, and the defluvium should be complete in a week. They may not do so, however, either from an insufficient dosage, an idiosyncrasy on the part of the patient or other cause, and the exposure may have to be repeated. Another fortnight is then allowed to elapse before further exposures are ordered. An interesting fact which is observed is that the healthy hairs around the patch more readily fall out than the affected stumps. Six weeks after the defluvium the hair begins to grow again, and a couple of months later new healthy hairs have grown in.

This method of treatment, if done with proper care, seems to be as safe as it is reliable. An adverse criticism has occasionally been made, however, to it—namely, that an exposure of the scalp to the X-rays for the time required to cause the hairs to fall out might have some serious effect on the underlying brain. So far no case has been reported to warrant such a fear, and the skull of even young children seems to afford sufficient protection. It would be unwise, however, to run any such risk in the case of an infant's scalp. It promises to be the method of the future, and is incomparably superior to any previous method both in the rapidity of the cure and in the comparatively slight amount of discomfort to which the patient is subjected.

CURRENT LITERATURE.

TREATMENT OF TINEA TONSURANS BY THE X-RAYS.

SABOURAUD and NOIRÉ. (*La Presse Méd.*, December 28th, 1904.)

IN 1896, four years after having begun the study of ringworm, Sabouraud wrote as follows: "Not only is there not any treatment at present known which cures ringworm, but I believe I am correct in saying that no antiseptic will ever attain this end. Because although the chemical nature of the antiseptics be varied their power of penetration is scarcely altered. The root of the hair is inaccessible to external antiseptics."

Since then he has abandoned all antiseptic treatment; and all his researches have been aimed at discovering an agent which would suspend the function of the hair-papilla. For three years the actions of depilating microbic toxins were tried, then the salts of thallium, but with negative results. In radio-therapy, however, a solution to the problem has been at last discovered. This treatment at first gave uncertain and varying results. Some authorities found it necessary to apply the X-rays as often as five to ten times on the same patch, and the treatment ceased to be practicable, while others found that in four or five months afterwards infected hairs grew on the patches previously treated. The cure, therefore, was not permanent. Again, others had calamities such as radiodermatitis causing permanent cicatricial alopecia. A simple and practical method has now been devised by Sabouraud which obviates these difficulties. The apparatus employed, and which has been installed in the "*École laillier Hôpital St. Louis*," is as follows.

There are two static machines, one with twelve plates and the other with ten, driven by motors worked by the hospital electric light plant. These are in a separate room enclosed in glass cases, to protect the machines from the variations of humidity and to free the operator from the noise. Insulated wires from these pierce the wall into the operating room, where they are connected with the X-ray tubes. A regulating tube is used and a sparking gap of 10 cm. is placed in the circuit; the wire at the side of the tube being heated with a Bunsen burner when the tube becomes so hard that the 10 cm. gap is sparked across. The tube is enclosed in a metal case, which has an opening towards the patient's head through which the rays pass; this opening can be altered in size by means of an iris diaphragm to fit a series of metal cylinders varying in diameter according to the size of patch to be treated, but not varying in length. The length is such that the patient's head shall be 15 cm. from the anode. The one thing still wanting is a method of measuring the quantity of rays given off by the tube in a given time. For this the pastilles of Holzknacht were first used; they consist of a mixture of alkaline salts, which change colour slowly under the action of X-rays. It is graduated to a scale of 12 divisions, each unit being called an "H." It has been found to be unsafe to go beyond 5 H at one *séance*. The disadvantages of these pastilles are: (1) They are a patent and secret preparation; (2) their price is very high (2s. 1d. each) as they can only be produced from one source; they can be used, it is true, several times, but the colour rapidly becomes inaccurate; and (3) after exposure to the X-rays the colour of these pastilles goes on changing a little in the daylight, and thus is inexact at the end of an operation. In spite of these difficulties, they were, however, able to discover by their means the correct

times of exposure for the machines, and without any accidents they had over 100 cures in series in five months.

It then became necessary to do some repairs to the motor, which resulted in increasing by one third the rate of rotation of the static machines, and in causing a series of erythemas and cicatricial alopecias. These showed that a simple method of measuring the total number of X-rays necessary to produce complete depilation at a single sitting was required. Fresh researches ended in the discovery of the radiometer X of Sabouraud and Noïré. It consists of paper coated with an emulsion of platino-cyanide of barium in a collodion of the acetate of amyl; this changes colour under the action of X-rays. It was then easy to obtain a standard water-colour tint, and when the pastille reached this tint sufficient rays had been used to produce total depilation without going so far as to cause an erythema.

This colour is the "teinte B" of Sabouraud's and Noïré's radiometer, and it corresponds to "5 H" of Holz knecht.

The drawbacks to it are that: (1) The pastille returns to its normal colour rapidly when exposed to daylight; if then the machine works in daylight the pastille must be placed in a roll of black paper. Moreover, when it is desired to look at the colour in daylight it must be done so quickly. (2) These pastilles are less sensitive to the X-rays than those of Holz knecht, and must be placed only 8 cm. from the anode, that is to say halfway between the skin of the patient and the anode; whereas Holz knecht's are placed at the same distance as the skin. (3) The pastille must be placed on a metallic surface which is impermeable to the X-rays, such as iron, not aluminium. As long as the pastille does not pass the teinte B there is no danger; even if the *séance* is long it only proves that the source of X-rays is feeble; but, if one goes beyond this tint accidents will happen varying in severity according to the times and different parts of the skin.

To cure a patch of ringworm by X-rays, then, one must place the patch 15 cm. from the anode or centre of the tube, a pastille must be placed 8 cm. from the anode, and when the pastille has reached the "teinte B" the operation is over.

A scalp which has been treated thus shows nothing until the seventh day, when a slight, scarcely visible erythema appears, which passes four days later into a faint pigmentation; from the fifteenth day the hairs begin to fall out all over the circular area treated, and the defluvium is complete in a few days, the hairs coming out without being pulled. The X-rays are not parasiticides at any rate under the above conditions, and if cultures are made from the fallen hairs, even the last give positive results invariably.

The regrowth is slow; this apparent drawback to the method is one of the reasons of its success; the last infected hair falling out a long time before the new hairs grow. The growth is visible two months after the operation, and is complete three months later. The two static machines work eight hours a day, and six days a week; the larger one does twenty-five *séances* in the day and the smaller fifteen.

The child's head is examined first, and the variety of ringworm recognised, then if there are not more than five patches, circles are drawn around each patch leaving a border of about 1 cm. of healthy scalp at the periphery; these circles are painted with tincture of iodine, and the hairs cropped close with scissors. All the patches are treated *seriatim* on the same day. If there are more than five patches the whole scalp is usually depilated. This is done by making six

large circles—two on the temples, one on the vertex, two on the parietals, and one on the occipital, taking care that the circles do not intersect. Each circle treated is covered by a piece of lead kept in place by an elastic band; these being thus protected the spaces in between the circles are done in six more *séances*, the whole twelve being done without any intervals. From the day of the operation, while waiting for depilation, an oil of cade ointment is applied to the whole head every evening (oil of cade, 10 grammes; lanoline, 25 grammes); and is washed off with soap each morning. After the morning washing the whole head is treated with: Tincture of iodine (fresh), 10 grammes; alcohol (60 per cent.), 90 grammes. This is to prevent the hairs when they fall infecting healthy and untreated regions, since one must remember that the parasite is alive.

Again one often finds at the edges of the circles a little impetigo occurring at the same time as the depilation; this is cured in a few days by applying the following ointment: Sulphur precipitate, 10 grammes; alcohol (90 per cent.), 10 grammes; distilled water, 80 grammes.

On the thirtieth day an inspection of the whole head is made to be certain that there are no infected areas, however small.

The results show that whereas ringworm was formerly cured in two years, it is now cured in three months, or freed from infection in one month.

The treatment of ringworm by X-rays has caused the "Assistance publique" since January 1st, 1904, the up-keep of 150 beds, representing 1,500,000 francs.

Before 1903, the ringworm children lived at the *école lailler* on an average two years or rather more. The school having 300 pupils, 110 annual cures were sent out. From January 1st, 1904, to December 15th, 1904, with a reduced school we had 327 cures. The cost of a child is 2 fr. 80 centimes a day. An average cure, therefore, used to cost 2000 fr.; it now costs 260 fr.

W. S. FOX.

THE TREATMENT OF NÆVUS BY X-RAYS. J. R. LEVACK. (*Scot. Med. and Surg. Journ.*, July, 1904, p. 33.)

THE writer here describes three cases of Nævus flammeus (port-wine stain) in which treatment by the X-rays was adopted and gave successful results.

Case I was that of a girl aged 8 years, with a large naevus occupying the left side of the face from the temple down to the upper lip. A patch 1½ inches in diameter was first treated, the rest of the face being protected. Daily sittings of ten minutes each were given. A 10-inch spark coil worked from six accumulators, with a hammer-break interrupter and a soft tube were used. After three weeks of this no reaction was obtained, so an electrolytic interrupter was substituted, and the current from the main employed so as to give 100 volts and 7 amperes. Daily sittings of three minutes set up a violent reaction in a fortnight, with œdema and vesication, and the skin peeled off. The raw bleeding surface healed very slowly, but when the patient returned three months later the part was completely healed and free from naevus. The rest of the naevus was subsequently treated in the same fashion in two *séances*, and the result was equally satisfactory. The writer advises that the whole of a naevus should be treated at once instead of piecemeal.

Case II was that of a woman aged 38 years, who had a naevus on the left half of the upper lip, which extended in isolated spots on the naso-labial fold and lower eyelid. The main portion was treated as above, and a reaction produced in about

six weeks, the outlying islands being treated by the electro-cautery. The result was satisfactory.

Case III was that of a woman aged 54 years, with a naevus of about one and a half inches in diameter, situated on the left malar prominence, dusky red in colour, and raised above the level of the surrounding skin. There was another patch on the right ala nasi and one on the back of the left wrist. This case was also successfully treated.

[We congratulate the writer on the successful treatment of these three cases. Still, we cannot help feeling that the method is one which should not be lightly undertaken without carefully explaining to the patient the tediousness and discomfort of the prolonged healing process, and the possibility of a telangiectatic scar being produced which would be even more unsightly than the naevus.]

J. M. H. M.

ON PAGET'S DISEASE. JUNGMAHN AND POLLITZER. (*Derm. Zeitschr.*, Bd. xi, Heft 6, p. 391.)

AFTER a short review of the literature, especially that of cases of Paget's disease elsewhere than on the breast, the authors proceed to detail their own case. The patient was a woman, aged 46 years, whose mother had died of carcinoma, aged 73 years. The disease began in the left axilla as a small red, lentil-sized discharging patch. In a year's time it had reached the size of a florin, and had continued to spread until in four years' time it was as large as the palm of a child's hand. Up to this moment it had always been diagnosed as eczema, and it was then that the patient came under the care of the authors. It was then excised with no success, but continued to spread, and a few months later the patient began to notice the presence of a tumour in the axilla. The patient's general health began to give way greatly at this time, and the loss of weight was considerable. She was then treated by means of the X-rays and radium and was demonstrated later in the Society of Physicians with considerable improvement. In fact, with the exception of a narrow band the whole of the skin lesion had healed and the deeper trouble was showing progressive resolution. There is a detailed histological examination differing in no particular from that usually seen in such cases, and there are very successful drawings of the clinical and microscopical condition.

For those wishing for the literature of what may be called ectopic Paget's disease the article will be of value.

A. W.

A CASE OF LUPUS ERYTHEMATOSUS WITH ERYTHEMA INDURATUM. POLLAND. (*Derm. Zeitschr.*, Bd. xi, Heft 7, p. 482.)

THE patient was a woman, aged 49 years, who had no family history of tuberculosis as regards her parents, but who had lost two sisters from lung disease. The present illness began five years before with the appearance of slight red spots on the face which resembled insect-bites. Soon after tumours from the size of a pea to that of an hazel-nut appeared on the arms and legs, and after persisting for some months, disappeared. The condition of the face also improved, the patches disappearing with the exception of a slight atrophy, which was left behind. The condition then relapsed and all the symptoms reappeared, so that when she was

seen she had typical Lupus erythematosus, of a mild type, on the face, and on the legs, where there was a slight degree of varix, there were some nodules of indistinct outline, lying in the deeper layers of the skin, of a bluish-red colour and slightly tender on pressure. In no case was there any tendency to softening or rupture. A histological examination showed a fibrinous exudation, but nowhere typical epithelioid or giant cells. On the other hand, a large vein which lay in the part excised showed itself completely thrombosed, and filled with leucocytes. References to some of the literature are given. A. W.

ON THE RELATIONSHIP OF HYDROCYSTOMA TO GRANULOSIS RUBRA NASI. PINKUS. (*Derm. Zeitschr.*, Bd. xi, Heft 9, p. 642.)

THE patient was a man, aged 59 years, who had suffered from a red and hyperidrotic nose since his childhood. For some years little nodules had been appearing on his nose, but as they did not cause any symptoms he did not worry about them and only came to the hospital on account of a pityriasis rosea.

The skin of the lower half of the nose from the lower end of the nasal bone to the junction of the lip was slightly thinned, moist, bluish-red and covered with small whitish points corresponding with the mouths of the follicles. In this hyperidrotic area there were embedded a number of well-defined foci, consisting of reddish-white centres of the size of a pin's head, occasionally slightly raised and surrounded with a dark red border. The centre of the focus appeared cystic, and the red border could be made out with a lens to consist of radial vessels. There were at most 30 of these bodies present. The patient had suffered for months with some lung affection and had cold, blue hands and feet. There is an illustration in the paper of the reconstruction of one of these tumours by the wax plate method, and it shows a cyst in connection with a very much coiled duct. This is compared with another reconstruction illustration of a normal sweat-gland from the vola manus (surely it is a dangerous thing to compare a sweat-gland from the nose with that of the palm in order to demonstrate abnormality in the former. It is well known that there is nothing more marked in the skin than the regional variation of the size and arrangement of sweat-glands! A. W.)

A. W.

A CONTRIBUTION TO THE HISTOLOGY OF GRANULOSIS RUBRA NASI JADASSOHN. BAUMER. (*Derm. Zeitschr.*, Bd. xi, Heft 9, p. 640.)

THE appearances seem to be fairly characteristic, consisting of a mass of plasma cells surrounding the upper part of the sweat-duct immediately beneath the epidermis, cystic dilatation of the coil itself, with here and there pressure, flattening of the epithelium, and greatly dilated vessels, both blood and lymph, throughout the affected region. A. W.

THE CAUSE OF ALOPECIA PRÆMATURA. SOLGER. (*Derm. Zeitschr.*, Bd. xi, Heft 9, p. 648.)

A SHORT article calling attention to the propriety of regarding premature baldness from its effect on sexual selection. The author rightly points out that a bald woman at thirty would be regarded with something like loathing, whereas baldness in man does not constitute a disadvantage from the point of view of marriage. A. W.

ON A FURTHER INOCULATION FROM A CHIMPANZEE INFECTED WITH SYPHILIS. LASSAR. (*Derm. Zeitschr.*, Bd. xi, Heft 8, p. 558.)

THIS is a short report of the result of inoculation of a second chimpanzee from the lesion produced on the first animal, already published. The article does not say what form of lesion was used for the second inoculation, whether one of the primary sores or a secondary symptom. The second ape became affected with typical primary and secondary syphilis in the same way as did the first, but shortly after this it unfortunately died of acute military tuberculosis.

A. W.

ON AN INTERESTING CASE OF LEPROA MUTILANS. DEMETRIADE. (*Derm. Zeitschr.*, Bd. xi, Heft 9, p. 611.)

THE patient was a man, aged 40 years, who had first noticed two years before a perforating ulcer, first on his right and then on his left sole. These were treated without much success for some time, and when brought into the hospital considerable mutilation of the toes had occurred, and an X-ray photograph showed very marked rarefying osteitis in them. Numerous attempts were made to find the bacilli; and, although the date is not given, apparently in one slide only a few were discovered coming from the serum and pus of the ulcers. There was no other sign of the disease either in the form of eruption or thickening of nerves, and although the soles were the seat of diminished sensation there was no actual anaesthesia. The patient was treated by the injection of oil of chaulmoogra, beginning with $2\frac{1}{2}$ grms. per diem and reaching 5 grms.

A. W.

A CASE OF DIFFUSED LICHENIFICATION OF THE FACE. PAUTRIER. (*Rev. Prat. Mal. Cut. Syph. et Ven.*, July, 1904.)

M. PAUTRIER describes two cases of this rare condition, the like of which he has been unable to discover in so rich a museum as the St. Louis.

CASE 1.—A woman, aged 30 years. Till 4 or 5 years of age she had suffered from impetigo of the scalp and limbs accompanied by the formation of large, thick crusts. At 11 years an attack of jaundice resulting from a shock, then an eruption of pustules on the face, some suppurating and discharging freely. This lasted six weeks, when the skin resumed its normal condition. She remained well till the following December, when, with the onset of cold weather, a fresh attack occurred, and this has been repeated every winter since.

Each attack is ushered in by a most intolerable itching of the skin of the face. She cannot keep from scratching, and as a result the skin is reddened, somewhat oedematous, and oozing in places a clear serous fluid, which stiffens linen. The submaxillary and cervical glands are hypertrophied and tender. The oozing lasts about six weeks, the skin becoming dry, thickened, hard, and rugose, the pruritus persisting the whole time. Gradually the attack subsides, the skin, however, never returning to normal, but remaining slightly hardened and dry. From March to November the patient is free from symptoms unless she gets over-tired, eats fish, or drinks alcohol, when the pruritus returns for a few days.

The condition in February, 1903.—The skin of the whole face is in a marked state of lichenification, absolutely immobile, all expression is gone, and the patient

has the appearance of wearing a mask. A closer examination shows a regular network formed by parallel lines cutting one another, giving rise to small squares or lozenges. Each attack is preceded by a folliculitis of the forehead, lips, chin, and ears.

CASE 2.—A woman aged 25 years. From 15 to 19 years of age she suffered from facial acne, which disappeared about the twentieth year. Two years later the patient, in order to whiten the skin, rubbed the face for several days together with a piece of flannel soaked in soap, which resulted three weeks later in an attack of facial eczema. Three months later, at the beginning of spring, an irritable patch appeared on the right cheek, which recurred at each monthly period, clearing up in the intervals. In the spring of 1902 she had a more severe attack which resulted in thickening of the skin and oozing in places. Early in 1903 this condition was diagnosed as lichenification with secondary eczematization of the skin of the face. Under the microscope hyperkeratosis was found with marked thickening of the granular layer and hypertrophy of the interpapillary prolongations. The derma showed chronic infiltration of lymphocytes, with appreciable sclerosis, especially in the sections stained with orcein. The connective-tissue bundles were much thicker, more dense, and more intricate than is normal.

Both patients are neurotic and emotional, though it is doubtful how much of this state is due to the awful condition the two cases found themselves in. Examination of the gastric juice showed digestive irregularities in each. For a short time Unna's resorcin paste, 50 per cent. applied for forty-five minutes at a sitting, seemed to be of benefit by the intense keratolysis it produced. At the present time Pantrier says he should not hesitate to have recourse to the high-frequency current, by which means he should expect to bring about a cure which all other methods tried had failed to produce.

A. S.

SYPHILIS. (*Special Number of the 'Practitioner,' July, 1904.*)

THE July issue of the *Practitioner* is given up to a series of articles by various authorities on syphilis. A brief *résumé* of a few of these articles will doubtless prove of interest to the readers of the *British Journal of Dermatology*.

The first paper is from the pen of Dr. Paul Gastou, and deals with the history of syphilis in France since the time of Ricord. To Bassereau, the contemporary of Ricord, is largely due the idea of the duality of venereal diseases, which was completely established by Rollet in 1854. The next great advance was the recognition by Doublet, Mabon, and Diday that, apart from acquired syphilis, there was also an inherited or congenital type. This subject of congenital syphilis was reduced to order by Fournier and his pupils; then came the controversy with regard to the inclusion of tubercles and general paralysis among the syphilides and the further conception of parasyphilis; finally the period of bacteriology, with which the names of Lustgarten, Jullien, de Lisle, and Horand are associated. Up to the present time, however, no one has been able to prove the specificity of any organism discovered. Side by side with the bacteriological researches there have been many attempts to inoculate animals with the disease. It was tried in 1866 by Auzias-Turenne, and since then by Lancereaux, Martineau, Fournier, and Barthélemy, and all attempted to inoculate apes with it. Recently it has been placed on a scientific footing by Roux and Metchnikoff, who have successfully

inoculated apes with human syphilis, and have been able to induce an artificial immunity in the animals by means of an attenuated virus produced by passage from one animal to another.

"To sum up the whole matter: if we cast a comprehensive glance over the course travelled by students of syphilis since Ricord, taking as our guide Professor Fournier and his numerous works, based entirely upon statistics, our attention will first be arrested by such monumental discoveries as parasymphilis and late hereditary syphilis; but on looking to right and left we shall notice that as we advance in knowledge so do pathological data tend to take precedence of mere clinical observation."

Wickham contributes a paper on mercurial injections in the treatment of syphilis, a subject on which his large experience at the Hôpital Saint Lazare in Paris has rendered him a competent authority. The obvious advantages of the method are the sparing of the stomach, the more direct penetration of the mercury into the blood-stream, the more complete utilisation of the dose administered, and above all, the more exact dosage thus rendered possible. The dosage must be adequate, and the knowledge of the amount requisite can only be gained by cautious experiment, the limit of dosage being recognised when a reaction is produced by it, such as malaise or slight fever. Wickham draws special attention to the fact that insufficient attention is paid to the quantity of pure mercury contained in the various salts employed. He points out that calomel contains 84.9 per cent. of mercury, cyanide of mercury 79 per cent., corrosive sublimate 73 per cent., and biniodide only 44 per cent. The site of inoculation which he prefers is the buttock at the intersection of two lines through the junction of the upper quarter with the lower three quarters of the buttock, and one through the junction of the internal third with the external two thirds of that region. A circle with a radius of 2 cm. may be traced around this point, and in this area injections may be safely made into the muscles. Intra-venous injections, specially in thin subjects, are strongly advocated by the writer. The mercury is injected into the cephalic or basilic vein. By this method the mercury is very rapidly absorbed and the operation, if skilfully done, causes no pain.

The syringe most strongly recommended by Wickham is made entirely of glass (by Wülfing and Luer). It is made in all sizes and graduated to contain 1, 2, 3, or 5 c.c. The procedure in administering intra-muscular and intra-venous injections is fully described, and the various preparations of the soluble and insoluble mercurial salts are discussed. The writer strongly advocates the intermittent treatment by a series of courses, each followed by a period of rest in which the treatment is discontinued. This prevents the patient from becoming habituated to the drug. Out of the first twelve months five should be devoted to treatment and seven to rest; in the second year there should be four months of treatment out of the twelve, and in the third year three of treatment. Each course of treatment lasts about four weeks. He employs daily injections of the biniodide of mercury and iodide of potassium. At the next course "grey oil" (mercury 20 grm., sterilised lanoline 12 grm., sterilised fluid vaseline $\bar{a}\bar{a}$ 100 c.c.); of this 6 c.grm. is injected at intervals of five days. The writer finds that certain local manifestations of syphilis yield more readily to particular mercurial preparations. For example, syphilis of the mouth and tongue resolves best under injections of calomel, while in cases of general paralysis and tabes dorsalis injections of soluble salts are better.

Dr. Karl Touton contributes a paper on the treatment of syphilis in Wiesbaden, and strongly advocates the carrying out of treatment at a watering-place in order that the mercury may be combined with the hydrotherapeutic measures there to be had. The spring which is mainly used in Wiesbaden is the Kochbrunnen, which is a simple salt spring containing 6-8 per mille of sodium chloride, and issues at a temperature of 68.7° C. The increased ingestion of sodium chloride is believed by the author to be rational, and to facilitate the action of the mercury by inducing solution and consequent assimilation of the mercurial salts. This action is further augmented by the warmth of the spring-water. Salt baths stimulate the skin, and are said to increase the general metabolism of the body.

The method of treatment recommended not only by Touton, but by other specialists in Wiesbaden, is thorough mercurial inunction. In the rare cases of absolute idiosyncrasy towards cutaneous administration he has recourse to injections of salicylate of mercury or of the double chloride of mercury and sodium. The cure can be undertaken at any time of the year, as the hotels and various hydropathic establishments remain open all the year round. Before breakfast the patient drinks 200-400 grammes of Kochbrunnen, which is taken cold if the patient be constipated. About two hours after breakfast he takes every second day a bath of Kochbrunnen at a temperature of about 35° C., which lasts for about twenty minutes. After the bath an hour's rest is ordered, and the inunction is made, using a 33½ per cent. ointment of mercury on a basis of resorbine. Large surfaces of the skin are covered at a time, so that in three days the whole of the skin has been treated. The inunction lasts ten minutes, 3 to 5 grammes of ointment being employed. An hour before the midday meal the patient drinks a further 200 grammes of Kochbrunnen, and sometimes the same quantity about four o'clock. The course lasts from thirty to forty days. This *régime* is modified according to the type and condition of the patient. In conclusion, he strongly upholds the practice of not beginning mercurial treatment till the diagnosis is absolutely definite.

The treatment of syphilis at Aix-la-Chapelle is dealt with by Dr. Anton Lieven. As in Wiesbaden the action of the mercury is augmented by the drinking of water containing a large percentage of salt, so in Aix-la-Chapelle sulphur-waters are used to enhance the effect of the drug. Inunction is also the procedure in favour at Aix-la-Chapelle, and this is used in conjunction with the external application and internal administration of the mineral waters natural to the place. The sulphur-water is believed to open the mouths of the glands and follicles, and so to increase the absorption and assimilation of mercury, and the alkalinity of the waters promotes desquamation. The treatment lasts on an average from four to six weeks, according to the nature of the case; and it is made a custom to give at least fourteen additional inunctions after all the symptoms have disappeared. In the tertiary stages the "cure by inunction" is combined with the administration of iodide of potassium or sodium. The iodide is given by the mouth till absorption of the gumma begins. Then it is continued in the form of injections of iodipin (25 per cent. solution of iodine in sesamoid oil). Like Touton, the writer considers that the only treatment which is permissible before constitutional symptoms break out is of a purely local character.

Sir Alfred Cooper contributes a short paper on the Zittmann treatment of tertiary syphilis. This form of treatment is valuable as a substitute for mercury

and the iodides in cases of malignant syphilis which have reacted badly to the drugs. The principle of it consists in the elimination of the poison from the system by sweating and purgation, and the course of treatment lasts fourteen days. The patient is kept in a room maintained at a temperature of 80° Fahr. The purgative used is calomel, and this is prescribed in a decoction containing sarsaparilla.

Syphilis in children is discussed by Dr. George Still. He points out that though congenital syphilis is rarely detected at birth, still manifestations of it are present much more often than is supposed, such as snuffles, lesions in the fundus oculi, enlarged spleen, and "syphilitic pemphigus." On the other hand, he mentions a case in which congenital syphilis was not noted in a child till she was seven years of age, when an interstitial keratitis was detected. In 69 per cent. of his cases skin eruptions were present, and a noticeable feature of them was the mixture of specific and non-specific lesions. The treatment advocated is the grey powder by the mouth—half a grain three times a day with a grain of sod. bicarb. and two grains of pulv. cretæ aromat. If there be a tendency to diarrhœa, one eighth to half a grain of pulv. ipecac. co. may be added. In severe cases inunction is resorted to. The infants should be breast fed, and in older children careful attention to hygiene, and tonics, such as malt and cod-liver oil, are of great value.

These do not exhaust the list of papers in this issue of the *Practitioner*; for, among others, Dr. Mott writes on syphilitic disease of the brain, Dr. Ernest Lane on serum treatment in syphilis, and Dr. StClair Thomson on the treatment of syphilis in the upper air-passages. We most heartily congratulate the editor on the publication of this most valuable special number.

J. M. H. M.

KERION CAUSED BY MICROSPORON. BARGUM. (*Monatsh. f. prakt. Derm.*, July 15th, 1904, p. 84.)

It is well known that ringworm due to the microsporon is unusually rare in Germany, although series of cases have already been described from Hamburg and from Strasburg. But kerion due to microsporon does not appear to have been previously described in Germany, and the following case has therefore a certain interest. The child was aged eight years, and two other children in the same house had had ringworm which was caused by the microsporon. The mother of the child stated that she first noticed two white, bald patches on the scalp, which she treated with shampooing and rubbing with oil. In consequence of this, the diseased patches became inflamed, and when seen by Bargum they were covered with thick crusts, and there were in addition some small pustular and crusted lesions on the occiput. The lesions smelt offensive, but no diagnosis was made until the scabs had been removed, when two reddish inflamed patches, covered with pustules, made their appearance. The patches were infiltrated, especially in the centre, and on pressure pus could be forced out from the lesions, and at the same time hairs were expressed from the pustules.

Hair-stumps removed from the diseased scalp and from the crusts showed typical microsporon growth, but none of the stumps came out with the hair-bulb attached. Cultures were also made from the diseased hairs. Treatment rapidly cured the affection.

J. L. BUNCH.

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LICHEN PILARIS, SEU SPINULOSUS.

By H. G. ADAMSON, M.D, M.R.C.P.,

Physician to the Skin Department, Paddington Green Children's Hospital.

*(Concluded from page 54.)**

THE RELATIONSHIP OF LICHEN SPINULOSUS WITH OTHER AFFECTIONS HAVING FOLLICULAR SPINES OR PLUGS.

ALTHOUGH this affection has been, from a clinical point of view, so sharply marked off from other types, yet it is well recognised that similar lesions to those occurring in Lichen spinulosus may be present not infrequently in conjunction with other eruptions.

Lichen scrofulosorum.—Dr. Colcott Fox has frequently pointed out that these fine filiform spines may in rare instances be present in Lichen scrofulosorum, and he has insisted upon the difficulty that may occur in arriving at a correct diagnosis in consequence. Indeed, in the earlier cases this, as will be seen from the examples quoted above, was one of the chief points of discussion. The eruption of small pin-head-sized grouped follicular papules of Lichen scrofulosorum, occurring usually in childhood, bears a very close resemblance to that

* In the previous section, when discussing the examples of this affection recorded in French literature, I omitted to refer to the fact that the title "Lichen spinulosus" is frequently associated in this country with the name of Devergie. The term Lichen spinulosus (Devergie) first occurs in an early edition of Dr. Radcliffe-Crocker's *Diseases of the Skin*, but without any reference, and Dr. Crocker tells me that he cannot now trace the origin of this association. I have myself been unable to find any mention of this eruption or of the expression Lichen spinulosus in any writings of Devergie to which I have access.

of Lichen spinulosus, and when in rare instances the filiform spines are present in addition, the resemblance is still more marked. The diagnosis rests chiefly upon the presence in the former cases of more inflammatory papules, sometimes with pustular summits, and of tubercular manifestations in the form of enlarged glands, scrofuloderma, etc.

Miliary syphilide.—Dr. Colcott Fox has also observed similar spines in the small grouped miliary papular syphilide. But this, he states, is of very rare occurrence.

Lichen planus.—The disease, however, in which filiform spines are more often seen is that of Lichen planus, usually in the type of Lichen planus with acuminate lesions. This type is now so well recognised that it is unnecessary here to dilate upon its characters, nor to refer to the controversy as to its identity or non-identity with Pityriasis rubra pilaris (Lichen acuminatus). It may be recalled that the acuminate lesions consist of more or less raised papules with central follicular plug, and that they have a tendency to run together into groups forming nutmeg-grater-like patches, and that, especially upon the legs, the elements of these patches may increase in size and coalesce to form raised infiltrated *hypertrophic patches*—Lichen planus hypertrophicus or Lichen planus verrucosus.

The acuminate lesions may be present either in association with the ordinary plane lesions, or they may occur alone, or perhaps with only a few typical planus lesions, or with lesions of the buccal mucous membranes. It sometimes happens that the lesions, especially those about the neck, present horny filiform spines, like those of Lichen spinulosus, so that the patches are indistinguishable from those of the latter affection, except for their association with more typical Lichen planus lesions, or with the larger acuminate lesions or hypertrophic patches.

Dr. Pringle, I believe, was one of the first to call attention to this association of Lichen planus and Lichen spinulosus, and it is interesting to note, as will be seen from a case which I quote from Dr. Pringle's case-papers of the Middlesex Hospital, that as early as 1895 he was accustomed to use the term *Lichen plano-pilaris*.

DR. PRINGLE'S Case (Middlesex Hospital. Dec. 31st, 1895). T. N—, aged 36 years. *Lichen plano-pilaris*.—There are lesions on the inner side of each cheek, and a patch of Lichen planus, the size of half a crown, on the right arm two inches below

the olecranon. There is also a band of Lichen pilaris on either side of the neck. The patch on arm itches much.

The following cases exhibited at the Dermatological Society's meetings also illustrate the occurrence of filiform spines in this form of *Lichen planus*.

Dr. PRINGLE's Case (*Brit. Journ. Dermat.*, vol. ix, p. 74, 1897).—A woman, aged 36 years, with a skin condition which he regarded as a severe example of *Lichen spinulosus* (*vel pilaris*). Most marked patch on outer aspect of left leg, two inches below head of fibula, oval, 2 inches by 1½ inches; raised above skin, dusky pink areola, studded with horny plugs or spines, hard, nutmeg-grater-like. In centre of patch spines very large, and tops flattened, probably from friction. The intermediate skin of patch was congested, infiltrated, and thickened. Three smaller and less developed patches on outer side of right leg. On the sides of the neck were a few patches more closely resembling the not infrequent Lichen pilaris of children. Here the central follicular plugs were not nearly so hard as on the legs, and they were filiform, tapering to a fine point. No signs of other forms of lichen elsewhere, and no lesions on mucous membranes. (Abridged note.)

Dr. Pringle considered that it was an exaggerated example of the condition not by any means rare in children and universally termed Lichen pilaris in them. He had seen it co-exist with Lichen planus in more than one instance, and believed it to be of common origin with that disease.

Dr. COLCOTT FOX, February 12th, 1902, vol. xiv, p. 91, exhibited a young man, a railway clerk, the subject of the *acuminate form of Wilson's Lichen*. Disseminated over the trunk and limbs were miliary, acuminate papules, rather hard in consistence, rough to the touch, with a protruding horny spine, surrounded or not by a little congestion, and seated at the pilo-sebaceous follicles. This eruption was sparse, except on the legs, where every hair-follicle seemed to be affected. There was a marked tendency to grouping in places, and this was very noticeable on the side of the neck. On the legs were a few typical plane papules larger in size, violaceous, flat-topped, smooth, and glistening, with a polygonal outline and a central orifice. On the face were some larger stains and atrophic marks left by lesions, though arsenic had not been administered. A few similar stains existed on the flexor aspects of the wrists. The buccal mucous membrane in the region of the molar teeth was thickly studded with pearly papules. The eruption was of three months' duration, and the patient did not complain of any disordered sensation. The palms and soles, scalp, nails, and fingers were unaffected.

Dr. Colcott Fox called attention to the typical plane lesions, to the buccal lesions, and to the follicular elements on the limbs like Keratosis pilaris, and to the groups which closely resembled those seen in *Lichen spinulosus* (Devergie).

Dr. J. J. PRINGLE (February 12th, 1902, vol. xiv, p. 96) brought forward a remarkable example of *Lichen spinulosus* in a man aged 69 years. The lesions had begun two years ago on the scalp, and had appeared on other parts of the body seven months ago. There were patches of lichenification situated with marked symmetry on the supra-clavicular and supra-spinous regions, over the backs of the fore-arms, over the fronts of the fore-arms just above the wrists. Two asymmetrical patches lay obliquely in the mid-dorsal region on the right side. When first seen the patches were studded with characteristic horny spines projecting nearly a line; these had been removed by treatment, and the patient now presented only marked peri-follicular keratosis surrounding large black follicular plugs or comedones which could easily be expressed. The patches on the scalp presented similar characters. The disease began immediately after a grave business disaster. No Lichen planus papules were present, but there was a leucoplasial patch of doubtful significance inside the left cheek.

P. 168, vol. xiv, April 9th, 1902. Dr. Pringle reported at the next meeting that the spinous patches were slowly involuting, but that within the last week an abundant eruption of absolutely typical Lichen planus had appeared on the inner side of both knees and adjacent parts, thus justifying his original diagnosis.

Mr. MALCOLM MORRIS (February 12th, 1902, vol. xiv, p. 94) showed a case of *Lichen planus* in a woman aged 51 years. The disease chiefly affected the lower extremities, and took the form of brownish papules and plaques, with here and there marked central atrophy of the skin almost amounting to scarring. A peculiar feature was the occurrence of acuminate, follicular papules, with horny spines round some of the ordinary patches.

Dr. COLCOTT FOX (July 13th, 1904, vol. xvi, p. 340). Wm. W—, aged 10 years. *Lichen planus of Wilson with acuminate and plane lesions*.—The eruption had been developing for several months, and now was distributed over the greater part of the trunk and limbs, but the face, palms, soles, and mucous membrane of the mouth were free, and the flexor aspects of the wrists nearly so. The special feature of the case was that the bulk of the lesions were miliary in size, acuminate in form, with marked protrusion of horny spines, and without clinical evidence of inflammation.

They were to a certain extent distributed in patches, but not notably so, and individually were indistinguishable from those met with in the Lichen spinulosus of Devergie. Interspersed amongst these miliary lesions, chiefly on the abdomen, was a scanty proportion of dull, red maculo-papules, from a pin-head to a split pea in size or somewhat larger. Some papules were raised and infiltrated, and presented in a striking manner the opaline streaking in papules of Lichen planus. Others did not project above the level of the skin, but, whilst looking rather atrophic, felt like thin parchment let into the skin. There was no itching. A remarkable feature was the occurrence on the backs of the digits and dorsum of the hand of minute black-headed follicular plugs, as in Pityriasis rubra pilaris.

In the two following cases there were very numerous small follicular lesions apparently of the nature of *Lichen spinulosus*, although it is not distinctly stated that there were projecting spines.

Dr. ORMEROD (June 11th, 1902, vol. xiv, p. 268) showed a case of *Lichen*

planus with acuminate papules. Pallid feeble-looking girl, aged 16 years. Principal part of eruption on limbs. The neck and upper arms (chiefly outer aspect) covered with small closely-set papules, flesh-coloured, conical, firm, and containing a plug of epithelium. In the centre of some of them a hair was seen. They gave the skin a rough feeling like exaggerated goose-skin. On outer aspect of elbow, and upon fore-arms and wrists, were thickened, dull red, somewhat scaly areas with irregular margins; some smaller dull red papules which looked like an eruption of *Lichen planus*. . . . The thighs showed numerous pale conical papules like those on the arms. On inner aspect of knees, and upon front of both tibiae, were thickened, hard, red patches, whose surface was covered with grey desquamating epithelium. The eruption began with the pale conical papules, afterwards running into the red scaly patches.

Dr. COLCOTT FOX, on October 13th, 1897, exhibited a case of *chronic folliculitis in circumscribed patches, disseminated over the face and neck, trunk, and limbs*. (*Brit. Journ. Dermat.*, vol. ix, p. 448). A young man, aged 21 years (E. W. E.). The aspect of the patches was quite peculiar. They were distributed sparsely on the forehead, on the neck below the right ear, behind the right ear, on the inside of the lower third of the left thigh, the outer side of the left calf, over both trochanters, on the left side of the sacrum, behind both knees, on the front of the left tibia, and on the back of the left forearm. The patches on the forehead presented the aspect of diffuse congestive chronic rounded areas, in one of which atrophy was evident. Possibly these face lesions were not of the same nature as the others. Over the other regions aggregations of follicles became affected and plugged, and attracted attention as black-topped, miliary, comedo-like points, with hardly any congested element. Gradually each comedo-like lesion became erected into a conical papule. As these papules became crowded they coalesced to form plaques, reddened, pigmented, rugose, thickened, faintly scaly, as in *Lichen planus*. These patches varied from the finger-nail to two or three times the size. The lesions were essentially indolent and chronic. The patch on the side of the neck, which was clearly compounded of follicular lesions, displayed some atrophy, but so far not the other areas. Itching was often considerable. Dr. Colcott Fox compared and contrasted it with other patchy follicular eruptions, finally with cases which had recently been shown at the Society, in which grouped follicular lesions ran together to form plaques similar to those in *Lichen planus*, but he doubted whether the acuminate follicular lesions might occur in true *Lichen planus* to the exclusion of all typical *planus* lesions. In the light of these cases now quoted this may be looked upon as of the nature of *Lichen planus*.

In the patient of Dr. Pringle (shown on February 12th, 1902) the *planus* lesions only appeared subsequently. This was also the case in the following example, which Dr. Pringle has kindly allowed me to quote from his private case-book. Here it will be seen that although there were present at first only the follicular lesions, yet the later appearance of typical *planus* lesions confirmed the early suspicion as to the true nature of the case.

Mrs. Q—, aged 60 years. April 6th, 1904. *Lichen spinulosus* old diabetes.

Skin eruption on back about five months; began about waist, now on back. Said to have diabetes (under Dr. Pavy eight years ago), but now well (?) Shows lesions of Keratosis (lichen) follicularis in groups all over upper back and scattered indiscriminately over the arms. No planus anywhere. Much itching, and this also in scalp, which is seborrhoeic. Said to have some itching about privates. Nil on mucous membranes. A very sensible, well-balanced person. Urine acid, 1015; no albumen, no sugar.

Subsequent Note.—Improvement. Only persists on back and shoulders and down arms to level of deltoid insertion, especially interscapular region. Same keratotic type as before.

Later Note.—An old scratch mark half an inch long in centre of left forearm shows lesions like Lichen planus all along it.

The following case exhibited by Dr. Stowers at the meeting of the Dermatological Society of Great Britain and Ireland, on February 22nd, 1899, is the sole example of grouped Lichen spinulosus in an adult, without Lichen planus, that I can find amongst the cases recorded in this country. The note that considerable itching was complained of seems to me significant and to suggest that the case was one of Lichen planus type rather than an unusual example of Lichen spinulosus in an adult.

A case of Lichen spinulosus.—The patient was a female, aged 32 years. The eruption was stated to have commenced, nine months ago, between the breasts, and to have gradually developed. At present it involves in a roughly symmetrical manner the upper part of the chest in front, upon and between the breasts; behind, there was a large space between the scapulæ quite free, but a circular arrangement of spinous papules around that area existed. Considerable itching was complained of. Dr. Stowers considered the case a well-marked example of Lichen pilaris or Lichen spinulosus. The President, Dr. Crocker, thought it an unusually marked example of that disease.

Hallopeau's three cases of *Acné cornée* in adults may be recalled in this connection; it will be noted that in the first case pruritus was severe, and in the second there was scarring and pigmentation, significant perhaps of Lichen planus.

The question then arises whether there is an etiological relationship between Lichen spinulosus and Lichen planus. In adults, certainly, the presence of grouped spiny follicular lesions strongly suggests that Lichen planus lesions will also be present if looked for, or that they will subsequently appear, and the spiny papules may be regarded as an undeveloped form of acuminate lesion. Itching is generally present in these cases. In the typical cases in children, however, there is nothing to suggest a relationship with Lichen planus. The lesions

do not itch and neither acuminate nor plane lesions of Lichen planus are present. This is the rule in the large number of examples I have quoted. The case by Dr. Fox in a boy aged 10 years is the only exception in which planus and spiny lesions were present together.

The following quotation from Liveing's *Handbook of Diseases of the Skin*, 5th edit., 1887, p. 161, possibly also relates to cases of this class: "*Inflammatory Lichen pilaris*. . . . I have twice met with cases in which the sole lesion appeared to be circumscribed patches of large, highly inflamed papules, distributed about the upper part of the back, shoulders and neck, with casts of the follicles protruding from their mouths. The appearance, except as to colour, was like Keratosis pilaris, but the distribution in rounded, well-defined patches on the neck was quite different, and *the irritation and itching were intense*. The history was that of an inflammatory disease from the first, and not that of an accidentally inflamed Keratosis pilaris."

Pityriasis rubra pilaris.—Filiform spines may also occur in *Pityriasis rubra pilaris*. Dr. Radcliffe-Crocker, in his *Diseases of the Skin*, relates the following case: "In a boy with a very partial attack, affecting the face and upper part of the trunk, there were a large number of papules of *Lichen spinulosus* about the neck and shoulders."

Although there can, as a rule, be no difficulty in diagnosing a case of *Lichen spinulosus* from one of *Pityriasis rubra pilaris*, yet, when the lesions are very abundant in the former affection, it will very much resemble the eruption of *Pityriasis rubra pilaris*. In a case of Dr. Crocker's already quoted (page 5), *Lichen pilaris seu spinulosus* in a boy aged 6 years, they were so closely set that the appearance of *Lichen acuminatus* was simulated, but neither on the face nor on the palms were there the usual signs of that disease.

The presence of the keratosis of the palms and soles, and of the face and scalp, and the rather larger size of the individual lesions, together with the characteristic lesions on the dorsal surfaces of the fingers, are, of course, the chief distinguishing points of *Pityriasis rubra pilaris*; in a case exhibited by Dr. Duffin, on February 11th, 1885 (Dr. Fox's notes, No. 301), there appears to have been difficulty in arriving at a diagnosis in spite of the presence of face and palm lesions.

DR. DUFFIN'S case.—*A very remarkable case, a follicular eruption (nearly universal) in an adult woman. The eruption consists of miliary papules, formed*

by elevations of the follicles, which are mostly plugged by an extruding spine, as in the Keratosis (? lichen) pilaris of children. The back of the neck is particularly affected, the cheeks to some extent, and the backs of the hands; the nails are involved. The palms are thick and horny. The face is also the seat of ordinary diffuse seborrhœa, and there are patches on the chest.

Note.—? Pityriasis rubra pilaris.

Again, in a case exhibited by Dr. GALLOWAY, on July 12th, 1899 (*Brit. Journ. of Dermat.*, vol. xi, p. 315).

A boy, aged about 2 years, who had suffered from the eruption to be described for about twelve months. On the front of each knee, and extending slightly down the leg, was a large single patch of erythematous skin, over which the orifices of the follicles were marked by acuminate horny papules. Over these areas there was constant slight desquamation of epidermis. Recently, numerous patches, circular in outline, had appeared on the trunk and extremities in which similar acuminate papules could be observed, with a slight amount of reddening and desquamation. The greater part of the body was quite free from eruption.

Dr. GALLOWAY brought the case forward as possibly an early stage of *Pityriasis rubra pilaris*. He based his diagnosis upon the facts that there were present areas of reddened skin, with desquamation on which acuminate papules of characteristic appearance had developed early in the course of the disease.

Dr. CROCKER considered the case a characteristic one of *Lichen spinulosus*.

Dr. PRINGLE and Dr. FOX also agreed with Dr. Crocker's diagnosis, but thought that certain of the individual patches were not distinguishable from *Pityriasis rubra pilaris*.

Keratosis follicularis contagiosa of Brooke.—Yet another disorder, in which fine, horny spines are said to form a prominent feature, is the *Keratosis follicularis contagiosa* of Brooke. Very few cases have been described, and some of these it is difficult, from the descriptions, to distinguish from *Lichen spinulosus*; indeed, the entity of this affection is perhaps hardly established, other cases closely resembling Darier's *Keratosis follicularis*, of which, possibly, they may have been early or undeveloped forms. In order to clearly present the position of this disorder it will be necessary therefore to consider somewhat fully the few cases that have been included under this designation. The affection was first described by Brooke in the *International Atlas of Rare Skin Diseases* (1892), with Plate XXII. Brooke there states that the affection had already been described by several authors, but that the fact that it might be contagious had not been noticed before. He gives an account of three families of children affected. In the first family there were six cases; in the second, three; in the third, one only. Brooke's plate gives the idea of a

disorder quite distinct from *Lichen spinulosus*. The arms of the child (extensor surfaces shown), from the shoulders to the fingers, are seen to be closely studded with lesions, which apparently consist of small black specks, intermingled with millet-seed-sized, red raised papules with black specks at the centre, so that the general appearance is that of an *Acne vulgaris*; there are a few lesions on the face and trunk. On referring to the description of this case (which is too long to quote here in full), one reads that the lesions consist essentially of plugged follicles, either plugged with black-topped comedones or with long filiform spines; the spines, which are most marked at the nape of the neck, are hard and brittle. Around these primary lesions there develop papules, some inflamed like acne spots, others more like minute acuminate warts. Large fleshy papules are also mentioned. After a time the papules and skin around them take on a yellowish-brown pigmentation, so that the affected areas present a distinctly dirty appearance. The eruption spreads from the nape to other parts, and ultimately affects the forehead, lip, cheeks, posterior fold of axillæ, shoulders, extensor aspect of limbs, trunk, buttocks and flexor aspects to a less degree. The other children in this family (six out of seven) became similarly affected.

In another family, in which three children were affected, the first, a boy, aged 5 years, had similar lesions, but to a less pronounced degree. The whole body was more or less affected, but particularly the posterior axillary fold, popliteal sinews, nape of neck. On the back, the spines protruded from the follicles without any signs of redness or papulation. In the sister and brother the whole extensor surfaces of the legs and arms were slightly involved. The only place where the lesions were inflamed was at the nape of the neck, where a few were reddened.

In the third family only one child was affected, a boy, aged 5 years. Here, the nape, shoulders, outer surfaces of arms and legs (inner sides almost free), dry nutmeg-grater-like surface; no actual spines.

The chief points of difference between these cases and *Lichen spinulosus* appear, then, to be, that the former are contagious (or at any rate occur in several members of one family), that there is not the same tendency to grouping, that in addition to the horny spines there are larger papules, some of an inflammatory nature and some, as shown by the histological examination, due to the retention of the

products of hyperkeratinisation. From the picture and description of the first case it would be easy to imagine a form of Darier's disease, but neither Brooke, nor Wickham, nor Unna (who examined lesions from Brooke's case) found the typical "psorosperm" bodies in the lesions. Individually the cases in the other two families appear to differ from Lichen spinulosus only in that the plugs and papules appear to be larger and the plugs harder than in Lichen spinulosus, so that hard dry nutmeg-grater-like surfaces are formed. Dr. Brooke would himself appear to admit the close resemblance between these two affections, for, in a paper read at the Third International Congress of Dermatology, 1896 (*Transactions*, p. 123), he says: "The *Lichen spinulosus* of Devergie is very similar in its early stages, but it does not reach the same degree of development, and always occurs, in my experience, in circumscribed areas."

As to the pathology of Brooke's affection, he states that it is essentially a hyperplastic growth of the epithelial cells, with modification of horning process, allowing them to retain their vitality for a longer period than usual and permitting of their permanent adhesion. The exciting cause acts from without, the chief points of attack being the common follicle of the hair and sebaceous gland; but it is not confined to these parts, as there is a marked Keratosis also of many sweat-ducts and in some of the deeper superficial furrows. The first step is a comedo-like plug which becomes brown or black like an ordinary comedone. The comedone as it grows distends the follicle and broadens at the base and thus cannot penetrate the corium, so drags up the epithelial layer attached to its mouth and thus forms a papule. Sometimes the papular formation is assisted by an exudation of inflammatory cells round the neighbouring vessels, but when present this slight inflammation appears to be due to the irritation caused by the new growth.

If we examine now the cases of Brooke's disease described by other authors, we find that they are very few. Brooke himself quoted several writers as having previously mentioned it, viz. Cazenave (*Acné sebacée cornée*), Hardy (*Acné sébacée cornée*), Guibot (*Acné sébacée cornée*), Leloir and Vidal (*Acné cornée*), E. Wilson (*Ichthyosis sebacea cornea*), Lesser (*Ichthyosis follicularis*); and he states that the term *Lichen spinulosus* has also been applied to it.

Now, as we have seen, Cazenave's *Acné sebacée cornée* covered a wide

field, so that it is possible that it may have included this affection; but as I have already tried to show, Hardy, Leloir, and Vidal were dealing with our *Lichen spinulosus*. E. Wilson's *Ichthyosis sebacea cornea* has been claimed for Darier's disease. Guibot's description of *Acné sebacée cornée* has already been quoted as referring to *Lichen spinulosus*.

Lesser's case is as follows :

Lesser 'in Ziemssen's 'Cyclopedia,' "*Ichthyosis follicularis*."—A boy aged 6 years. Over the extensor surfaces of the extremities, most markedly on the wrist and ankle, besides on the face, over the brow, nose, and auricular edges, thin compact scaly columns, even as long as a millimetre, whitish or greyish in colour, are seen projecting from a large number of follicles. The flexor surfaces of the trunk are very much less affected, and the soles and the palms are entirely free. On the scalp, which centrally has a few isolated hairs and peripherally a scanty growth, these epidermal spines may be seen projecting from a number of hair-follicles. The eyebrows are entirely wanting, and in this region the affection is very marked. Passing the finger over the diseased part produces a sensation like that caused by the prickly surface of a rose-leaf.

[This case, except for the unusual affection of the eyebrows or for the loss of hair, would easily pass for a case of *Lichen spinulosus*. The affection of the scalp and eyebrows and the occurrence of horny spines on an erythematous base leave little doubt, however, that it is the rare affection described by Taenzer (*Monatssheft*, 1889, vol. viii, p. 197), under the name *Ulerythema ophyrogenes* and which is regarded by Dubreuilh as a form of *Keratosis pilaris*.]

Brooke also claimed two cases published in America, viz. the well-known case of Morrow of universal spines in a young sailor (*Keratosis follicularis*) and White's case (*Keratosis follicularis*). White has since shown that his case was Darier's disease. Morrow's case, to my mind, does not conform to Brooke's description.

MORROW'S CASE. C.O.—aged 21 years, a sailor. The eruption began five years ago on the backs of the hands, soon after upon the neck, arms, and body. It has continued ever since, though getting better on land and worse at sea. The entire surface of the body, except the face, the palms, and the soles, is the seat of a follicular disorder. The ducts of the sebaceous glands project above the surface, and are occupied by round or comedo-like substances, greyish or dark in colour, some of which protrude in the shape of spinous prolongations, more or less prominent. Many of these spinous projections are one quarter to one half an inch in length. They are longer and more abundantly present over the back of the neck, the abdomen, posterior surfaces of the arms, thighs and legs. When pressed out they present a greyish, horny, somewhat glistening appearance. They are hard and perfectly dry, and rattle like dried peas when thrown on to a sheet of paper.

None of the follicles show evidence of irritative or suppurative action; their presence does not cause the slightest inflammatory reaction.

The tongue is large and deeply fissured. The buccal mucous membrane is opaline or bluish-white in appearance and presents plaques which are superficially fissured. This condition is specially noticeable along the line formed by the junction of the teeth when closed. Patient says the tongue has been white and a little sore ever since he can remember. Conjunctivitis and slight Kerato-iritis, possibly syphilitic in origin, was considered, but the history negated this.

Histological examination showed it to be a keratosis of the follicular mouth, extending down into the sebaceous gland, which became distended by the lower end of the plug. There was slight secondary dilatation of vessels and cell-exudation around.

The long history and the universal distribution of this eruption together with its association with the mouth lesions, seem to me to make it unique, and I should hesitate to place it either with Brooke's cases or with the ordinary type of Lichen spinulosus.

As regards other cases published as examples of Brooke's disease, there are, so far as I am aware, those only of DuCastel and Baudouin, Barbe, Elliot and Little. I have already quoted the cases of the French observers as examples of Lichen spinulosus. I shall now recall Little's cases and that of Elliot. Little's cases, to my mind, are not convincing as examples of Brooke's disease, although they differ in some respects from Lichen spinulosus.

Dr. GRAHAM LITTLE'S Cases. A case of *Keratosis follicularis* (*Brit. Journ. of Dermat.*, vol. xiii, p. 51).—William A—, aged 8 years: has had affection for six months. Child in good health. No subjective symptoms. Other children in family not affected. Groups of closely aggregated horny papules, with a central black plug projecting about one sixteenth of an inch above the papule. Surface of skin feels like a coarse nutmeg-grater. Distribution symmetrical; a patch about size of florin, with the individual papules arranged in a whorl-like manner on the inner surface of both legs just below inner condyle of tibia; a smaller patch of same appearance over internal condyle of femur on both sides; irregularly scattered papules in the popliteal hollows; grouped, closely aggregated papules in the fold of the groin, and on the external surface of the thighs, about two inches below the anterior superior spine of the ilium. There are scattered horny papules on the supra-pubic regions, and a small group arranged in a whorl on either side of the umbilicus. There are about forty papules rather smaller than those forming the groups irregularly dotted over the abdomen and on the chest up to the level of the nipples. On both arms there are individual papules sparsely distributed over inner aspect of upper arm and in folds of elbow; on backs of both arms, over deltoid muscles, are a few small papules; none on the backs of elbows. A few papules on shoulders and on neck, none on face or scalp.

Two other cases were shown by Dr. Little at a subsequent meeting of the Dermatological Society of London, October 9th, 1901 (*Brit. Journ. of Dermat.*, vol. xiii, p. 417).

Two cases of *Keratosis follicularis* in two sisters.—(A) Elizabeth McN—, aged 6 years, has been troubled for twelve months with the present skin affection. This consists of closely aggregated homogeneous, acuminate, follicular papules raised about one sixteenth of an inch from the surface of the skin and of a pink-buff colour, with a crater-like depression in the summit of the papule. These are grouped chiefly in circinate forms, forming nummular patches with papules so closely aggregated as to present a surface like that of a coarse nutmeg-grater. The skin between the papules is slightly scaly. There is no itching. The distribution is strictly symmetrical. On the extensor surface of each upper arm there is a patch about the size of a shilling. On each thigh an almost continuous sheet of acuminate papules stretching from the iliac crests to the knees on the outer surface. Symmetrical patches on the buttocks. Small, sixpenny-sized groups of papules on posterior surface of each thigh. Over internal and external condyles of the femur are grouped circinate shilling-sized patches, and a nummular patch on each calf, about two inches below the ham. There are also discrete papules upon the extensor surfaces of the upper arms and upon the legs, and early papules forming patches along the lower anterior wall of the axilla on both sides. The skin everywhere else seems normal, and the child is otherwise quite healthy.

(B) Alice McN—, aged 13 years, has had chronic patches of follicular keratosis for three years, but of much less extensive distribution than in the case of her sister. There exists now (1) a five-shilling-sized patch on left knee over the internal condyle, and a less closely aggregated group of papules over the external condyle and head of the tibia; (2) a florin-sized patch on left buttock; (3) a patch the size of a threepenny-piece on the right buttock. The child has excellent health in other respects.

Since showing the above cases the third and only remaining child of the family, Thomas McN—, aged 2½ years, was found to have also a few discrete papules, not so salient as in the other children, but quite definite, over the condyles of the femur on both sides, on the front of the leg below the patella, and on the extensor surfaces of the upper arms.

Dr. Little remarks on the obvious similarity with Brooke's case of *Keratosis follicularis contagiosa*, and notes that *Lichen spinulosus* of Devergie has never been remarked to affect whole families in this way. Brooke, commenting on the notes of Dr. Little's cases, said that his cases were not quite so patchy as Dr. Little's seemed to be—they were more in sheets, covering large surfaces—but that he knew the patches described by Dr. Little.

These cases seem to conform to Brooke's cases, other than the case depicted in the *Atlas*, but it is difficult to say that they are not cases of *Lichen spinulosus*.

Elliot's case is reported as follows :

ELLIOT'S Case. *Keratosis follicularis contagiosa* of Brooke : *Acné cornée* of the French (*Journ. of Cut. and Gen. Urin. Dis.*, August, 1894).—With this diagnosis

Dr. Elliot exhibited to the New York Dermatological Society a male patient, aged 14 years, a native of Russia, who presented an eruption of about four and a half years' duration. It began on the upper portion of the back, and gradually spread, partially covering the face, trunk, and extremities. The lesions, for the most part discrete, were in some places aggregated to form large areas. They were pin-head in size, but also larger, slightly elevated papules, of a pale or darker red colour, containing in their centres a dark, hard, adherent plug, which, when forcibly removed, left a depressed pit, surrounded by a minute circular wall of infiltration. On the backs of the hands were large, pea-sized, fleshy papules, dark red in colour, bearing upon their central portions shallow pits, the bases of which were apparently slightly warty. There were no pronounced spines or horny prolongations.

Possibly this was a case of Brooke's disease, but personally I am unable to decide, and I transcribe the report without comment beyond the remark that there was no evidence of contagion: it was an isolated case.

In conclusion, then, if one recognises the existence of Brooke's disease as a clinical entity, one must admit that it is at least a very rare affection; it has been shown that the cases quoted by Brooke, as previously published examples of his disorder, belonged in reality to other well-recognised groups, *e.g.* Darier's disease, Lichen spinulosus. Clinically, Brooke's first case, depicted in the International Atlas, bears some resemblance to Darier's disease, while his other cases are more like Lichen spinulosus. The few examples since reported by other observers are not with certainty to be identified as such; they may be equally well claimed for other affections: some of them are undoubtedly Lichen spinulosus, others are only distinguished by the fact that several children in one family were affected.

Keratosis pilaris.—It seems hardly necessary to repeat that *Lichen spinulosus* should not be confused with *Keratosis pilaris*. Indeed, as I have already said, confusion can only arise from unfamiliarity with the less common disorder and from a similarity of names.

Keratosis pilaris is an affection of common occurrence, and in its milder forms seldom presents itself for treatment. In it the mouths of the pilo-sebaceous follicles on the extensor surfaces, especially of the upper arms and thighs, are the seat of a small horny cap or scale, which, together with a slight elevation of the follicle, give the appearance of a permanent goose-skin condition. The small adherent scales can be removed by the finger, leaving behind a slight and shallow pit. The follicular elevations are of the same colour as the

skin, or they may be slightly reddened. The scaly cap contains a rolled-up lanugo hair. There is no spiny projecting process, and there is no tendency to grouping of the lesions.

Unna has shown that the hyperkeratosis is limited to the mouths of the follicles, and that it there forms a sort of cap which shuts in the hair, which, in consequence, becomes doubled up or spirally twisted. It occurs chiefly in persons who do not bathe or who wash seldom or insufficiently.

Brocq says that this affection also attacks the scalp, the face, and especially the eyebrows, and to this type of case Dubreuilh has attached the rare affection described by Taenzer under the name of *Ulérythème ophryogène*, which has already been referred to above as the *Ichthyosis follicularis* of Lesser.

Clinically, a similar condition may occur in *ichthyotic* skins, although Unna regards this as pathologically distinct from *Keratosis pilaris*, and as representing a special incidence of the ichthyotic process upon the pilo-sebaceous follicles.

A CASE OF LICHEN PILARIS, SEU SPINULOSUS, WITH AN ACCOUNT OF THE HISTOPATHOLOGY OF ITS LESIONS.*

Boy, aged 8 years, always delicate, very fair complexion, hair almost white. Father's mother died of consumption. Patient has "winged" scapulæ, but there are no physical signs of chest trouble. The eruption is of about twelve months' duration, but no definite history of its origin can be obtained.

There is a spiny patch on the back of the neck to left of middle line, and three or four patches irregularly oval from a shilling to a florin in size over the upper part of the shoulders behind. There are similar patches on the outside of the arms and on the buttocks. The patches are made up of pale filiform spines, one projecting from each follicle, so that they are closely crowded together. They are about $\frac{1}{16}$ to $\frac{1}{8}$ inch in length. The mouth of the follicle at the base of the plug is slightly raised into a pin-head-sized papule. Some of them are pale, others slightly red as though mildly inflammatory. Over the arms and buttocks are also a few scattered discrete spines.

Pathology.—A small portion of tissue containing four or five spines

* This case attended Dr. T. C. Fox's clinique in 1904. Dr. Fox has kindly allowed me to quote it.

was removed for examination. It was hardened in Müller's fluid and sections were stained by various methods, viz. hæmatoxylin and orange rubin, hæmatoxylin and van Giesen, polychrome blue and orange tannin, and by various methods for the demonstration of micro-organisms and of hyalin.

The most conspicuous feature of the sections is the plugging of the follicles by a horny mass which distends the follicle at its upper third, and extends upwards for some distance beyond the level of the epidermis. In sections stained with hæmatoxylin and van Giesen the orange-yellow stained plugs stand out in contrast with the purple and red of the rest of the section. The plugs are made up of concentric lamellæ arranged in a cylindrical fashion around a persisting central atrophied hair. The lamellæ are composed of welded flattened horny epithelial cells, whose outline can sometimes be made out indefinitely, and in a few of which there is still present the remains of a badly stained central nucleus.

The walls of the follicle enclosing the plug are compressed and somewhat thinned towards the mouth of the follicle, but more deeply around the apex of the horny cone the follicular walls are widened and the cells are more or less polygonal and distinctly show prickles—*i.e.* there is a condition of acanthosis. In the cells nearest to the plug and here and there in cells a few layers deep are homogeneous irregular masses partially or wholly filling the cell between its nucleus and its wall. These masses take the same stain as the horny plug and represent the conversion of the prickle-cells into horn-cells, *i.e.* the process of cornification is irregular and analogous to that of the horny pearls of epitheliomata. There is a complete absence of keratohyalin granules as in the normal process of keratinisation. No micro-organisms were discovered in the plugs and no evidence of hyalin changes. The portion of the follicle below the horny plug appears normal, as also the hair it contains and the hair-bulb.

The sebaceous glands are altogether absent, or at any rate no sebaceous glands are seen, although in some of the sections a shrivelled mass of epithelial cells budding from the side of the follicle probably represents the remains of an atrophied gland. The sweat-glands are well developed.

The corium shows no cellular infiltration. There is possibly a slight increase of connective-tissue cells towards the neck of the follicle and

PLATE II.



FIG. 1.



FIG. 2.

TO ILLUSTRATE DR. ADAMSON'S PAPER ON LICHEN PILARIS SEU SPINULOSUS.

around the papillary vessels, but this is so slight as to leave doubts as to whether it is really in excess of the normal.

GENERAL REMARKS UPON THE HISTOPATHOLOGY AND ÆTIOLOGY OF
LICHEN SPINULOSUS OF CHILDREN.

Histopathology.—My own observations from the histological examination of a single case detailed above may be summarised as follows: A horny plug distends the follicle at its upper third and extends upwards for some distance beyond the level of the epidermis. It is made up of concentric lamellæ composed of flattened welded horny cells. There is an acanthosis of the cell wall. There is an absence of keratohyalin granules, the horny cells of the plug being formed by a process of irregular cornification. No micro-organisms were discovered. The hair-bulb is unaltered, but the sebaceous glands are atrophied or absent. There is a very slight increase in amount of cells of connective-tissue type at the neck of the follicle and in the neighbourhood of the papillary vessels. These findings, then, do not differ essentially from those of other hyperkeratoses of the pilo-sebaceous follicles. Unna has frequently pointed out that atrophy of the sebaceous glands, or rather return of the sebaceous cells to an epithelial type, is a common feature in all hyperkeratoses of the follicle where the plug reaches as far as the neck of the gland. He has also shown that absence of keratohyalin and irregular cornification, with retention of nuclei in the horny cells, is merely a mechanical result of the pressure of the plug. The same occurs in the cell-nest of epitheliomata. As regards the corium, in my sections, as already stated, I found little or no evidence of any pathological change. The increase of fixed cells around the follicle and in the neighbourhood of the vessels, was very slight, and certainly did not indicate any inflammatory action of importance. There were no leucocytes nor lymphocytes. From a histological point of view I should therefore regard the affection as non-inflammatory, and that the whole process is confined to the epidermis. It consists of a certain amount of acanthosis, with considerable hyperkeratosis. If we attempt to compare the histo-pathological appearances with those of other follicular affections, we find that the differences for the most part are too subtle for any very definite statements; and moreover the observations of

different authors do not always agree. The main difference between the various follicular lesions in Lichen planus, in Pityriasis rubra pilaris, in Brooke's Keratosis follicularis contagiosum, in ichthyosis, is in the amount and character of the surrounding cellular infiltration and in the presence or absence of, or in the difference in degree of, the acanthosis. The *Keratosis pilaris* of Brocq differs according to Unna in that the keratosis does not actually involve the follicle but is confined to its mouth, there forming a lid-like horny scale which shuts in the hair, the hair becoming twisted in a spiral and dilating the mouth of the follicle.

So far as I am aware, the only description of the lesions of Lichen spinulosus other than my own are those of Leloir and Vidal, of Giovannini, and the more recent observations of Andry; and of Hallopeau if we accept his cases of *Acné cornée*. In Leloir and Vidal's drawing the plug appears to occupy only the superficial part of the follicle, but the section is evidently oblique since the lower part of the follicle does not appear in it. Leloir and Vidal note the comparatively small amount of cell infiltration and also the atrophy of the sebaceous glands. They sum up by saying that there is a follicular hyperkeratosis with abnormal keratinisation, with absence of sebaceous glands, and that although there is a certain proportion of embryonic cells, yet the inflammation is very little marked.

Of Giovannini's paper I am unable to study the original, but from the abstract of it in the *Annales*, I gather that he found what he regards as a special form of atrophy of the sebaceous glands, in which the cells of the gland have returned to a primitive type like those of the Malpighian layer, and in which, instead of giving rise to the typical fatty sebaceous cells, they become cornified, and breaking through the connective-tissue septum which separates the hair-follicle from the gland, they grow into the follicle to form a horny plug at its orifice.

Hallopeau's description of the lesions in his second case of *Acné cornée* was, briefly, as follows:

An enormous dilatation of the orifice of the pilo-sebaceous follicle. The contents of the follicle consisted of perfectly keratinised horny cells, with fat in minimal quantity. There were no hard grains, as in psorospermosis, but certain rounded figures in some of the keratinised cells were observed in potash preparations of the plugs; these were

regarded by Malassez and Darier, who examined the specimens, as artificial and due to the action of energetic bases used in the preparation of the specimens. The derma subjacent to the follicular dilatations was sprinkled with round and fusiform cells in greater numbers than in the normal state, indicating a light irritative condition.

Audry's description of the histo-pathology of his case of *Kératose pilaire engainante*, which is to my mind a typical case of Lichen spinulosus, corresponds very closely with my own observations; it is as follows:

The epidermis of the fragment excised is absolutely normal; perhaps it shows a slight degree of hyperkeratosis characterised by exaggeration of the desquamating layers. The stratum granulosum is normal, as are the remaining epithelial layers of the derma. The sweat-glands are healthy. All the pilous follicles are altered and, in the same manner; they are filled with horny flakes concentrically arranged around a central hair.

The sheath of the follicle is formed of cells which are continuous with the Malpighian layers, of which they preserve the characters to a considerable depth. It is remarkable that the eleidin, very well developed in the epithelium of the sheath, does not extend beyond the neck of the follicle; in consequence, the horny transformation takes place actively before the appearance of eleidin. The thickness of the sheath is very variable; it increases sensibly in proportion to its depth. The cylindrical layer loses its character entirely. The fragment examined was too small and superficial to make it possible to give an account of all desirable details, and, moreover, the follicles were implanted very obliquely in relation to the integument.

However, it can be very well seen that there is always a principal central axial hair, but that there is also, usually, a secondary eccentric hair, so that certain follicles appear bifid.

The horny flakes descend a long way into the follicle. The eccentric hair in one section was, nearly to its origin, surrounded by two or three layers already horny, lamellated, with wasted and flattened nuclei.

The whole mass of horny lamellæ which fills the follicle is made up of layers, of which the keratinisation appears complete. It is only in the deepest layers, and those farthest from the centre of the

plug, that one sees numerous *débris* of nuclei, of a kind that they have the appearance of slight parakeratosis.

There is no inflammatory reaction in the neighbouring connective tissue.

Often, at the side of the follicle, with its hair and the horny sheath, one finds deeply invaginated epithelial buds which appear to be atrophied follicles.

It is very remarkable that no traces of sebaceous glands were found, though perhaps this is accounted for by the superficial biopsy. However, one may affirm that there was certainly a default in this direction.

Andry remarks on the *bizarre* nature of the lesions, that in place of the usual rolled-up hair of the ordinary Keratosis pilaris, it carries with it and around it the hyperkeratotic lamellæ. He thinks that the condition must be very rare, and says that he has never before met with it, and that he has never found it described in any work that he has read; it appears to him distinct from the lesions described under the name of Lichen spinulosus.

I think that there can be no doubt, however, that Andry's case is a case of our Lichen spinulosus, and his histological observations are closely in agreement with my own.

All observers agree that there is little or no evidence of inflammatory action around the follicle, that the sebaceous glands are atrophied, or absent, and that the horny plug is the result of an abnormal hyperkeratinisation in the follicle. Giovannini's view, that the horny plug arises directly from the sebaceous glands themselves, seems to me untenable.

Pathology and ætiology.—Although it has been stated by the best authorities that this affection is of inflammatory origin, histological examination, as we have seen, shows little evidence of this.

The statements as to the inflammatory nature of the lesions are based upon clinical observation. Dr. Crocker says that the lesions appear suddenly, that the eruption comes out in crops, a patch appearing perhaps in the night, and continuing to increase for a week by the development of fresh papules. After this, except that the papules grow paler, there may be no change for an indefinite time. He says, again, that it is an inflammatory disease of the follicles, that there is at first congestion of the vessels, followed by a

slight effusion round the follicle and hyperplasia of the epidermic cells following it.

Sir Cowper Perry also has expressed the opinion that the condition is one really of inflammatory origin, and that this is shown by watching the process of development of any of the individual lesions. At the commencement of the pathological process the site of the spine is surrounded by a red and vascular area, which ultimately forms the base of the papule. It must be noted, however, that in the report of Perry's case it is stated that the lesions had been present six months when the patient first came under observation!

Personally, I have been unable to verify the occurrence of this early inflammatory stage, and although I have seen the lesions reddened, I have regarded this as a secondary result of local irritation. Without, however, denying that the lesions are slightly inflammatory at their first appearance—from histological examination of the lesions—I am of opinion that the essential part of the process is a hyperkeratosis of the follicular wall, and I regard the slight elevation of the follicular mouth as due rather to an increase of the epithelial elements of the follicular wall and to the presence of the horny plug itself. I think, therefore, with Dr. H. G. Brooke, who has expressed the same opinion,* that the term *Lichen pilaris* given to the disorder by Dr. Crocker is an unfortunate one. Neither clinically nor histologically is there evidence of such inflammatory action as the term "Lichen" seems to suggest. The more appropriate name appears to me to be that of Unna, viz. *Keratosis follicularis spinulosa*.

As to what is the ultimate factor in the causation of this follicular hyperkeratosis we are still in the dark. We know that hyperkeratosis may be due to local mechanical irritation, as in corns and callosities. It is highly probable, too, that it may be due to local parasitic action, as, for example, in the common wart, in the hyperkeratosis accompanying old tuberculous or syphilitic lesions, perhaps in the follicular keratoses, Acne vulgaris, Brooke's Keratosis follicularis, Darier's disease. It may also result from toxic action, as in arsenical poisoning. There is no evidence that Lichen spinulosus is due to local mechanical nor to parasitic action, and the only alternative seems to be to regard it as of toxic origin. This, of course, is merely an hypothesis. Some support, however, is lent to this view by the fact that children

* *Transactions of the Third Congress of Dermatology*, p. 123.

affected are often pale and weakly and from the strong clinical resemblance of the lesions to those of *Lichen scrofulosorum*. In *Lichen scrofulosorum* it is now generally admitted that the lesions are not directly due to the tubercle bacillus, but that they are toxi-tuberculides. The follicular spines in *Lichen spinulosus* might be said to be secondary to the peri-follicular inflammation, but this to me seems to have little meaning and I should regard them as due to the same poison which is responsible for the peri-follicular lesion. The lesions of *Keratosis pilaris* and of *Pityriasis rubra pilaris* might equally well be explained on the same hypothesis—an unknown toxin. The question arises whether there is any ætiological relationship between *Lichen spinulosus* and *Lichen planus*. As we have seen, in adults, the presence of *Lichen spinulosus* always suggests *Lichen planus*, since acuminate or planus lesions are almost invariably present or subsequently make their appearance. The same association may occur in children, although this is the exception; in *Lichen spinulosus* in children there is generally no evidence of *Lichen planus* and the lesions are unaccompanied by itching. We are not warranted, then, in regarding *Lichen spinulosus* of children as ætiologically connected with *Lichen planus*.

Conclusions.—1. Under the name of *Lichen spinulosus* there is well known in this country an affection of the skin occurring in children, and usually in boys, which is characterised by the appearance of fine filiform spines arranged in groups, more or less symmetrically, distributed over the trunk and limbs. The filiform spines arise from pilo-sebaceous follicles, the mouths of which follicles are slightly raised to form pin-head-sized papules, either of the normal colour of the skin or slightly red. They are unaccompanied by itching or other subjective sensations, and there is little or no disturbance of the general health.

2. Similar cases have been observed in France, although there the affection is not so well known and it is apparently not recognised as a distinct entity. The cases recorded in France have been described under different names. The *Acné cornée* of Hardy and of Leloir and Vidal, and possibly also of Guibout is the same disorder, but the cases of *Acné cornée* observed by Hallopeau, with the exception of one case, viz. *Acné cornée en aires*, do not quite correspond to our cases of *Lichen spinulosus*. Other cases have been published by

Barbe as examples of Kératose folliculaire (type de Brooke) and just recently a case by Audry under the title Kératose pilaire engainante.

3. In addition to the typical cases of Lichen spinulosus in children, where the spiny lesions constitute the whole eruption, there are other cases in which such lesions are associated with an eruption of Lichen planus. Although this association may occur rarely in children it is more common in adults. In adults, indeed, the occurrence of the spiny lesions seems to be usually, if not invariably, associated with Lichen planus. This fact would seem at first to suggest some ætiological connection between the two affections Lichen spinulosus and Lichen planus; but further consideration shows that the purely spinous cases of children are without the subjective sensation of itching, while those cases associated with Lichen planus do usually present this symptom. Moreover, the spiny lesions in these latter cases are usually associated with the acuminate follicular lesions of Lichen planus, and it is most probable that they have therefore merely an accidental association with a perifollicular disturbance. Such an hypothesis is made more probable by the fact that similar spines are occasionally associated with the follicular lesions of Lichen scrofulosorum and miliary syphilide and also with those of Pityriasis rubra pilaris.

4. Histologically the lesions of Lichen spinulosus in children show that the pathological process is essentially a hyperkeratosis of the follicle; peri-follicular inflammation is absent, or at any rate very little marked.

ADDENDUM.

Since the publication of the first part of my paper in the February number of this JOURNAL, and while the concluding portion was still in the Press, my attention has been drawn by Dr. Pringle to an important article "Über Lichen Spinulosus," by Dr. Felix Lewandowsky, in the *Archiv für Dermatologie und Syphilis*, lxxiii, Band 2, u. 3, Heft. (February, 1905).

Dr. Lewandowsky gives a remarkably careful summary of the English literature and quotes most of the hitherto published English cases. He discusses the relationship with Aené cornée of French writers and refers to Brooke's disease, to Audry's case of "Kératose pilaire engainante," and to Baudouin's and Du Castel's case. He

remarks upon the paucity of reference to "Lichen spinulosus" in continental literature, finding only the brief mention of the affection by Brocq (in *La Pratique Dermatologique*, vol. ii, p. 140), who regards most of the cases as probably examples of Lichen scrofulosorum, and the short statement by Unna in his *Histopathology*, where he suggests the name of Keratosis follicularis spinosa. He then gives an account of a case observed by himself, together with the results of the microscopical examination of lesions. This case has a very important bearing upon the question of the nature and pathology of the lesions, confirming, if it be admitted to be a case of Lichen spinulosus, the tradition of English writers as to the inflammatory origin of the affection, a view which I have opposed in my paper. For this reason I shall quote the clinical notes of the case somewhat fully.

October 12th, 1902.—The patient was a girl, aged 9 years, who was suffering from kerion of the scalp. There was no other pathological condition. The child's mother had died from phthisis pulmonum, and the child had formerly been weakly and had suffered from coughs, but was now strong again. On October 19th the skin of the neck and shoulders suddenly became erythematous and covered with greenish-yellow crusts, probably due to infection of the pus from the kerion. This was soon cured. On October 23rd an eruption was noticed on the trunk. It was symmetrically distributed upon the breast, belly, and back. It consisted of small, intensely red, papular efflorescences of the form and size of a pin's head. The papules were firm to the touch, and, for the most part, very soon showed a central, glistening, epidermic scale, and, a few, a small pustule. By pressure one could squeeze out of the papules a drop of pus, which, under the microscope, showed pus-corpuscles and detritus, but which contained no bacteria and cultures of which remained sterile. These lesions were strictly limited to the follicles, and their arrangement was not everywhere the same. While on the breast and belly almost every follicle appeared to be attacked, on the sides and back the papules were not so numerous and more scattered. The skin between the papules was normal. A portion of skin was removed from the back for examination. During the next week the eruption continued, the papules on the sides and back became more numerous, and the affection spread over the gluteal region and on to the thighs. Here at the margins was a grouping of the lesions into circles of the size of 1-3 marks. There was no itching, little inconvenience, and so the eruption was allowed to develop without treatment. A week later there was no alteration, then, the papules, especially on the upper part of the trunk, all began to fade, and a striking alteration was noticed in the centre of the lesions, consisting in the formation of horny masses, 1-2 mm. long, lightly crumpled, rather hard bristles issuing from the centre of the papules. Stroked with the hand, they gave the sensation of a file (*reibeißen*). On November 19th a portion of skin with horny bristles was removed for histological examination. In December the eruption on the trunk was no longer distinguishable from the normal skin by its colour, but only by the horny spines. Papules were still

red upon the lower part of the back. All showed a tendency to disappear, and by the end of December there were no typical horny spines.

Histological examination confirmed the clinical observation that the case was really "a follicular affection of inflammatory nature with concomitant and, above all, with secondary parakeratosis or parahyperkeratosis."

The lesions examined showed three consecutive stages of the process. The process began with an œdema of the follicle wall, with "spongioid" condition and vacuolation of the outer layers of cells, the cells of the central layers separating and dissolving to form a cavity. White blood-corpuscles were seen passing through the œdematous follicular wall and collecting in the central cavity to form an intra-follicular pustule (the second stage). Sometimes the whole wall of the follicle became so infiltrated with white corpuscles that hardly an epithelial cell could be detected, though the infiltration never broke down the connective tissue around, as in Bockhart's impetigo. Meanwhile the mouth of the follicle was the seat of a parakeratosis. In the third stage the abscess dried up and the parakeratosis extended to the whole follicular wall, the lamellæ of adherent—partially keratosed—cells being thrust out to form the spine as fresh layers formed beneath. It was noted that the sebaceous glands were absent in all sections. There was a moderate cell infiltration in the surrounding connective tissue in the earlier stages.

Lewandowsky concludes that the eruption is essentially an inflammatory affection of the follicles and that the spines are a secondary phenomenon; that its onset would suggest a parasitic origin which was so far negatived by the absence of micro-organisms in sections and culturally.

If, then, one holds the view that the lesions of Lichen spinulosus are non-inflammatory, one must exclude Dr. Lewandowsky's case; the intra-follicular pustule and the parakeratotic spine do not belong to this affection. Even on clinical grounds, one cannot regard it as an example of our Lichen spinulosus: the appearance of distinctly inflammatory papules with a tendency to pustulation two or three weeks before the formation of the spines is in complete disagreement with the conception of English observers.

DESCRIPTION OF PLATES.

PLATE I.

Lichen spinulosus.—From a photograph of a water-colour drawing made by Miss Mabel Green and kindly lent to me for reproduction by Dr. T. Colcott Fox. The case was under the care of Dr. Colcott Fox, and is quoted on page 43.

The drawing illustrates very well the characteristic grouping of the lesions

the projecting horny spines are well shown, although they tend to project in one direction rather than in various directions as depicted; the slight elevation of the follicular mouths is not represented. [The photograph has suffered considerably in reproduction, especially in respect to the groups of spines on the front of the chest.]

PLATE II.

FIG. 1.—Drawing from microscopical section of lesion from the case of *Lichen spinulosus* reported on page 91 (low power).

Shows horny spines plugging upper part of follicle; absence of granular layer in this part of the follicle; absence of any marked cellular increase in the corium. There is no trace of sebaceous gland, nor was the gland seen in any of a series of sections through the follicle.

FIG. 2.—The root of the follicular plug under a high power shows the process of irregular cornification as described on page 92.

SOCIETY INTELLIGENCE.

THE DERMATOLOGICAL SOCIETY OF LONDON.

AN ordinary meeting of the above Society was held on Wednesday, February 8th, 1905, Dr. J. J. PRINGLE in the chair.

The following cases, etc., were exhibited:

Dr. COLCOTT FOX presented two cases for diagnosis.

CASE 1.—*A Prurigo-like Eruption*. A gentleman, aged 49 years, who had spent all his life in India and came to England for a holiday in April, 1903. His hair had been getting grey since the age of 38; and his skin generally was notably pigmented. He had enjoyed good health except for some malaria years ago, but was neurotic. The eruption commenced in October, 1903, became more intense in January, 1904, and was then accompanied by great itching and insomnia. When shown the itching was only experienced in the early part of the night. The eruption commenced on the arms, and became generalised, even involving the scalp, but the forehead and cheeks only slightly. Two medical men diagnosed urticaria. When shown the scalp was free, and the face practically so. The sides of the neck were involved, and all the trunk. The limbs were chiefly affected on the flexor aspects, but the palms were free, and there was but little on the flexor aspects of the wrists. The backs of the arms and the legs were getting lichenified

and were rough and harsh, and as if dusted with flour, but there were no free scales. The lesions were thickly set, discrete, disseminated without order except for some linear arrangement across the loins. The nails and the mucous membrane of the mouth were unaffected. The lesions were firm, prurigo-like papules, dome-shaped, often slightly reddened, the size of hemp-seeds. There was a marked absence of excoriation and formation of blood-crusts. They flattened down and to some extent simulated the papules of Lichen planus. There were no glandular enlargements. He was not in any way ill, but ate well, and had lost his insomnia. No visceral trouble could be detected. He had some linear atrophy in front of the shoulders.

The exhibitor said the eruption most nearly resembled prurigo of Hebra, but he was not quite satisfied with this diagnosis. There was no obvious urticarial factor now, and no special tendency to factitious urticaria.

CASE 2.—*Eczema and growths on the left back.* A labourer, aged 50 years, enjoying good health, was attacked with eczema on the shins a few weeks ago, and with papular eczema of the loins and upper buttocks three days ago. He stated that his attention had been attracted to swellings on his back twelve months ago last Christmas, but he did not suffer any discomfort or pain. When shown he had a more or less confluent mass of growths on the left back below the scapula, several inches broad, and reaching from near the mid-line to the junction of the back and side. The growths were the size of a small mandarine orange, and were movable over the deeper structures, but involved all the layers of the skin. They were smooth and rather brawny to the feel, except when compressed by the raising of the arm above the head. In two places the skin was becoming implicated and the seat of a violaceous blush.

The man had been a soldier, and denied having had syphilis, but confessed to gonorrhœa. There were no stigmata of syphilis about him, but his children seem to have all died in infancy, and his wife had miscarriages. There was no evidence of deep-seated trouble.

In the course of the discussion several members said that syphilitic gummata might remain without breaking down for years, and inunctions of ung. hydrargyri over the growths with large doses of potassium iodide internally were recommended. Some members thought lipomata a not improbable diagnosis, but the surgeons present were not in favour of this.

Dr. GRAHAM LITTLE showed (1) a case of *Urticaria pigmentosa* in an infant aged 20 months, in whom the disease had persisted from the age of one month, at which time it had been first noted. The eruption was very extensive, and covered the whole of the back and front of the trunk. It was in the form of pale lemon-yellow macules without any elevation of the lesions. The condition was very like that depicted in the plate on "*Urticaria pigmentosa*" in the St. Louis atlas. The pigmented patches became red and urticarial upon irritation in the way typical of *Urticaria pigmentosa*. There was no family history of importance.

(2) A case of *Lupus erythematosus* in a woman aged 34, the subject of Raynaud's disease. She had been sent up from the country by Dr. Laird-Cox, with a history of Raynaud's disease, and she described the condition of alternate pallor and cyanosis of the extremities in an unmistakable way. The lesions regarded as *Lupus erythematosus* were upon the backs of the fingers and on the dorsum of the hands. These lesions were worse in the cold weather, but did not disappear in the warm weather. The association of *Lupus erythematosus* with Raynaud's disease had been recorded before, but not frequently, and there must always be an element of doubt whether the disorders of circulation were not responsible for some of the appearances of the eruption. In this case there were, besides the lesions on the fingers and hands, some scaling with atrophy of the skin of the lower lobes of the ears, and there was a small patch of recent origin upon the scalp. The cutaneous disorder of the hands had lasted for three years, with ameliorations, as has been noted, in the summer.

Dr. J. M. H. MACLEOD showed a *Case for diagnosis*. The patient was a girl, aged 12 years, who presented herself for treatment at the Victoria Hospital for Children, on November 16th, 1904, suffering from a figured eruption, affecting chiefly the thighs and buttocks. The lesions on the front of the left thigh, where the eruption was most characteristic, consisted of raised, circinate, gyrate or irregular figures; some of these took the form of circles of about an inch in diameter, with a border of a quarter of an inch in width, while others consisted of portions of a circle, or formed wavy bands. A number of small, flat, papular lesions, varying in size from a split-pea to a finger-nail, were present. All the lesions were easily felt, as they were definitely raised.

In colour they had a pinkish-brown tinge, and they were not scaly. The presence of the eruption was not associated with itching. Spreading down from these defined lesions on the left thigh were a number of diffuse irregular patches of a brownish-yellow tinge. The lesions on the buttocks were similar in contour to those on the thigh, but were not so definitely raised. Discoloured patches, where lesions had involuted, were present on the forearms. The face and trunk were free from eruption. On the scalp there was slight seborrhoic dermatitis.

The eruption had been present for at least two months, and had begun on the left calf and thigh. Previous to that the skin had been healthy. An ointment containing ten grains each of sulphur and salicylic acid to the ounce was prescribed, and under this treatment the eruption had gradually disappeared, and by the beginning of January all that remained of it was a slight patchy discoloration of the skin. On February 8th, the day on which the case was exhibited to the Society, the patient again presented herself at the hospital suffering from a second outbreak of the eruption, which the mother had noticed on the previous evening whilst the child was having her bath. On exhibition the eruption was present on the right thigh and took the form of rings, the largest of which had a diameter of about an inch. The rings tended to coalesce to produce gyrate figures. A few small finger-nail sized patches with slightly raised borders were also noted. The diagnosis of the case presented considerable difficulty, especially when it was first seen by the exhibitor in the condition depicted in the coloured drawing shown to the Society. In certain of its characteristics it suggested an anomalous form of annular Lichen planus, but the age of the child and the rapidity with which the eruption disappeared under mild local treatment were against this diagnosis.

Though none of the members present ventured to give a definite opinion concerning the nature of the case, the tentative suggestion was made by several that it might be connected with the seborrhoic condition of the scalp and be an unusual type of seborrhoide.

Dr. J. J. PRINGLE brought forward (1) a case of *Scleroderma* in a clergyman aged 64 years, whose general health was said to be excellent. Although he had been submitted to medical examination for various trivial complaints, the condition of his skin had never been

observed to be abnormal. Probably the onset of the disease occurred about seven years ago, when he began to suffer from "irritation" in the legs, worst at night and in cold weather. The skin of both legs was typically sclerodermatous as far up as the knees, with shallow ulcers over the internal malleoli. The point of special interest in the case consisted in the existence of symmetrical bands of peculiarly thick sclerodermatous tissue, extending on both sides from the olecranon process to the top of the ulna. These bands measured an inch and a half in width at their upper, and half an inch at their lower extremities. They corresponded accurately with Head's first dorsal nerve-root area, although they did not cover the whole of that area at either end. No symptom had attracted the patient's attention to the existence of these sclerodermatous bands, which were first discovered by the exhibitor ten days previous to the meeting. Two dense sclerodermic patches were also present symmetrically in the thighs in the centre of Head's second lumbar nerve-root area.

Dr. PRINGLE also exhibited (2) a case of *Exanthematic Lupus erythematosus*, under the care of his colleague, Dr. Wynter, in the Middlesex Hospital. As the case was shown at the meeting of the Dermatological Society of Great Britain and Ireland in November, 1904 (see this JOURNAL, December, 1904, vol. xvi, page 470), no detailed report of it is necessary. A point of special interest in connection with it was the strong family history of tuberculosis, the patient's father and four brothers having died of "consumption." During her six weeks' stay in the Middlesex Hospital her temperature had been persistently high, but seldom exceeded 101° F. at night; her general malaise was extreme, she suffered from marked tenderness of muscle over the whole body, and her mental condition was almost sub-typhoid. She had no albuminuria, and there were no physical signs indicative of tuberculosis of internal organs.

Dr. STOWERS showed a case of *mixed Sclerodermia*. The patient, a girl aged 19 years, was the eldest of nine children. Her parents were living and well, also all brothers and sisters. A younger sister had Lupus on one cheek three years ago, which was excised. The patient became pregnant at the age of 18 years, and subsequently married. The child was born at full time without disorder, and subsequently died. The patient was short, spare, and ill-developed,

but had had no severe illnesses during lifetime, having suffered only from the ordinary ailments of childhood.

About eight years ago her mother discovered a small, round, white "patch" of skin one inch in diameter immediately over the left breast, and subsequently two small separate "patches" of the same character, one on each side of the original. These still existed and had the characters of morphœa or circumscribed sclerodermia. About two years ago the patient's mother noticed that the left arm was "thinner" than the right.

Condition when shown: The whole of the left upper extremity had a marked atrophied appearance, and the limb could not be fully extended owing to the unyielding and contracted integument. The actually sclerosed portions of skin (certainly the most marked) existed upon the flexor surface of the upper arm, but the forearm was involved (on both the extensor and flexor aspects) by a broad band of white, smooth, and toughened skin completely surrounding the limb, extending downwards to the wrist and over the dorsal aspect of the left hand. Incipient fibrosis was commencing on the palmar surface. The nails had no abnormal appearance, and subjective symptoms were absent. There was no evidence of concomitant disease, but dental caries was marked. The several morphœic lesions on the chest and upper arm had the characteristic ivory-white, smooth, and glistening appearances. In addition, very numerous minute injected blood-vessels were visible on the surface of the arm. This telangiectatic condition was more marked upon the forearm. The violaceous zone usually seen around an anæmic area had not been noticed in this case, but doubtless it existed in earlier stages. Sclerodermia had been attributed to a mental shock during pregnancy, but it was important to note in this case that the disease had commenced more than eight years ago.

Dr. PARKES WEBER showed a case of *Kaposi's "sarcoma,"* which will be published in full in a future issue of the JOURNAL.

THE DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.

A MEETING of this Society was held on Wednesday, January 25th, 1905, Dr. J. H. STOWERS in the Chair.

The following cases were exhibited :

Dr. GRAHAM LITTLE showed (1) a case of *frambæsi-form syphilis* in a man, a tailor by trade, who had inoculated the middle finger of the right hand in some inexplicable manner, and there had developed a chancre. The disease was not at first recognised, and he had, consequently, not been treated for it in the first instance. When he had come to the hospital, six months after the appearance of the primary trouble, he presented several points of unusual interest. (a) There were four papillomatous growths upon the lip, chin, and cheek, partly concealed by the hair of the beard, and covering areas varying in size from that of a shilling to a florin. They were not purulent, nor did they emanate any offensive odour. (b) All the nails on the left hand, except that on the fourth finger, and all those of the right hand, with the exception of those of the index finger and thumb, presented well-marked onychia. Upon the right palm there was a localised patch of hyperkeratosis the size of a florin. Besides these somewhat exceptional features, he had numerous typical papulo-squamous lesions on his body, and there were also depressions on the under surface of the tongue, the result of previous gummata. The right middle finger was still swollen and discoloured at the site of the chancre.

(2) A case of *tertiary syphilis* in a man, aged about 35 years, formerly a soldier, with a gummatus infiltration of the lip and tip of the nose, and a large chronic syphilitic ulcer on the front of the left leg. He had contracted the disease while in the army, and he had not been adequately treated in the earlier stages. The ulcer on the leg had been present for four or five years, but the nose had not become affected until four years after the appearance of the ulcer. The patient had not been able to attend very regularly, and, consequently, was not progressing satisfactorily.

Mr. ARTHUR SHILLITOE, in commenting upon the treatment of the patient, remarked that the dusting on of somatose was frequently of great benefit in chronic ulcers of this sort.

(3) A case of extensive *seborrhoic eczema* of the scalp, with an extraordinarily acute history, associated with nearly complete loss of hair. The patient was a woman, aged 30 years, in whom the condition had lasted for four months, and in that time she had become nearly bald. The whole scalp was occupied by a dense scaly deposit. There were no patches of disease upon the face or body. The severity of the scalp-affection suggested the possibility that the appearances of seborrhoic eczema concealed an early *Lupus erythematosus*.

This question was debated at the meeting, the majority of the members thinking that it was merely a severe case of seborrhoic eczema, but supporters of the suggestion that *Lupus erythematosus* might be present were not wanting.

Dr. V. H. RUTHERFORD showed (1) a case of *multiple sarcoma of the skin* in a man, aged 33 years, a clerk by occupation. There was a family history of phthisis. Ten years ago he fractured his left tibia, and since that time he had broken other long bones on three or four occasions on comparatively slight provocation. In September, 1904, he had an attack of hæmoptysis, which was followed by a slight cough, and three months later he first noticed a few small, painless tumours in the skin of the lower part of the abdomen. These gradually increased in size and number until he came to St. John's Hospital on January 11th, 1905. At this time there were about twenty-five semi-globular growths varying in size from a pea to a large chestnut, distributed upon the chest, abdomen, back, and scalp. They were freely movable under the skin, and those which had attained to the size of a cherry were covered with red skin in which could be seen dilated blood-vessels. Over two or three of the largest the skin had undergone degeneration, with the formation of a thin crust. The glands in the groin, axillæ and neck were enlarged. The man was pale, and he had lost flesh during the past two months. He had been given arsenic internally, and a few of the tumours had been exposed to the influence of radium and also to the X-rays, but without appreciable effect up to the present.

A small, pea-sized, growing nodule was excised from the skin between the shoulders. Microscopic sections of this stained with hæmatoxylin revealed a condition of fibrous tissue in which were seen a number of small, apparently rapidly growing, highly stained, young connective-tissue cells. The appearances presented by this early nodule evidently indicated a fibrosarcoma. It was hoped that a

specimen could be obtained from one of the well-developed, soft tumours for further examination.

(2) A case of *papulo-squamous syphilide* in a woman aged about 40 years, symmetrically distributed over the face, arms, and trunk.

Dr. T. MANNERS-SMITH exhibited a case for diagnosis. The patient was a girl aged 15 years. The right leg showed a "marbling" of the anterior surface, due to dilatation of the cutaneous vascular network. The left leg presented a similar appearance, but here the "marbling" was of a deeper hue. In addition to the dilated vessels, this leg exhibited small, slightly elevated, deep red papules, some of which were apparently extra-vascular. There were no varicose veins present in either limb. She also had some slight erythema of the face, and œdema under the eyes. The condition of the legs commenced at the onset of menstruation, which occurred at the age of 11 years. The affection of the face began somewhat later. Both the legs and face were stated to be worse at the menstrual periods. The thyroid gland was slightly enlarged. Otherwise the patient had good health. There was no history of rheumatism or of serious disease.

A microscopic examination of one of the above-mentioned small papules showed a clear, greatly hypertrophied horny layer, great development of the stratum granulosum and stratum mucosum, with flat, large hyaline cells in the latter. The lymphatics were dilated, and the blood-vessels enlarged and hypertrophied. The sweat-ducts were blocked up with hyaline material. The papule had in many respects, therefore, the characteristics of Lichen planus, though clinically there was no resemblance to this disease. The vessels of the whole specimen were dilated and their walls hypertrophied, and there was considerable pigmentation of the cutis.

Some members of the Society regarded the condition of the legs as an angio-neurosis due to the disturbance in the circulation consequent upon the early establishment of the menstrual function. The disease was considered by others as being an example of the "Asphyxia reticularis" of Unna.

Dr. ALFRED EDDOWES exhibited (1) a well-marked case of *alopecia in band form* in a young woman who suffered in a high degree from seborrhœa. The band was an inch wide, and passed completely from one ear to the other across the frontal margin of the hairy scalp.

When the case was first seen, the appearance presented by the diseased area differed in many respects from that seen in typical Alopecia areata. The spreading margin had the appearance of an extremely mild coccogenic sycosis, *i. e.*, the mouths of the follicles still contained long hairs passing through minute, yellow, greasy-looking crusts set in rather sharply-defined, minute, inflammatory areolæ. No club-shaped stumps were present. When the hairs were extracted from the active area, they came out whole with moist, adherent sheaths which, under a lens, appeared to be suppurative. The parts over which the disease had already traversed, and in which new hair was growing, showed coarse, open-mouthed follicles such as are commonly seen on the face of subjects of chronic acne. Both clinically and microscopically this case was not Alopecia areata, for it was seen that micrococci had quite replaced the microbacilli.

(2) A case of *Leucodermia of the scalp and non-hairy parts, the latter having a central pigmented spot in nearly every patch*. The subject of this very rare affection was a boy, aged 13 years. On the scalp were several symmetrical patches of white hair, while on each cheek, over the larynx, on the centre of the back, over the inferior angles of each scapula, and on several other parts of the trunk were symmetrical leucodermic patches surrounded, as usual, by increased pigmentation. The great rarity of the case consisted in the existence of *deeply pigmented small central points*, some of which could be felt like minute moles, while others were not obvious to the touch. The largest of these pigmented spots, which stood in the centre of its leucodermic field like the bull's eye of a target, was less than one eighth of an inch in diameter. To the naked eye, each spot was sharply defined, generally round, occasionally oval. Though some of them looked suspiciously like moles of long standing, neither the young patient nor either of his parents could remember seeing any of them before the leucodermia attracted their attention a few years ago. Such a case had been described, but Dr. Eddowes had never met with one before in his own practice.

Leucodermia was essentially a symmetrical affection, quite as much so as other essentially symmetrical diseases, like Lupus erythematosus. The apparent non-symmetry of the leucodermic patches in this boy was due to the fact, recognised by the elder Hebra and commonly observed, that the central line of the skin did not always exactly

correspond to that of the skull and spine. With this allowance, the symmetry was perfect.

Dr. EDWARD STAINER showed (1) a case of *Nævus linearis* in a girl aged 5 years. The patient had been exhibited at a previous meeting of the Society (*Brit. Journ. of Dermat.*, January, 1904, p. 30). Since that date the condition had showed no improvement. There had been frequent relapses of the discharging dermatitis, and the various methods of treatment adopted had failed to give satisfactory results. The general appearance of the nævus was gradually changing owing to a strong growth of hair which had appeared during the last few months.

Several members of the Society discussed the case, and various modes of treatment were recommended, among them being the application of a salicylic acid plaster, light touching with the actual cautery, and the X-rays.

(2) A case of *Keratodermia of the soles* of five weeks' duration in a boy aged 14 years. When first seen, a week ago, there were several patches of hyperkeratosis bordered by a zone of bright erythema, but at the present time these characters had mostly disappeared.

Hyperidrosis, which was not present at the first examination, was now quite pronounced in both hands and feet.

Dr. J. H. STOWERS remarked upon the frequent association of hyperidrosis and bromidrosis with keratodermia affecting the soles of the feet. He considered that the method, advocated by Thin, of steeping the stocking in a saturated solution of boric acid, and wearing when dry, a better plan than employing dusting-powders.

QUARTERLY SURVEY OF DERMATOLOGICAL LITERATURE.

HYPERÆMIÆ ET INFLAMMATIONES.

- Acne Rosacea**, Intra-Nasal Irritation Causing. W. LLOYD. (*Brit. Med. Journ.*, January 14th, 1905, p. 74.)
- Acne Teleangiectodes** (Kaposi). W. PICK. (*Archiv f. Derm. u. Syph.*, November, 1904, p. 193.)
- Acne Urticata**. WAELSCH. (*Archiv f. Derm. u. Syph.*, December, 1904, lxxii, p. 349.)
- Dermatitis Gangraenosa Infantum**, A Case of, the Bacillus Pyocyaneus in the Lesions. H. G. ADAMSON. (*Brit. Journ. of Children's Dis.*, February, 1905, p. 78.)
- Elephantiasis** of the Upper Extremity, A Case of. ALBERT MAYER. *Derm. Centralb.*, January, 1905, p. 102.)
- Erysipeloid**, with a Record of 329 Cases, of which 323 were Caused by Crab-Bites, or Lesions produced by Crabs. GILCHRIST. (*Journ. of Cut. Dis.*, November, 1904, p. 507.)
- Erythema Scarlatiniforme** (Influenzal). JAS. HAMILTON. (*Brit. Med. Journ.*, January 21st, 1905, p. 131.)
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XANTHO-ERYTHRODERMIA PERSTANS.

By H. RADCLIFFE-CROCKER.

THE above provisional clinical title was suggested to me by my coadjutor at University College Hospital, Mr. George Pernet, for a well-defined affection of the skin, of which I have met with ten instances during the last three years, all but one of them in private practice. I am not aware that the disease in question has been described before, unless it can be brought under Brocq's "*erythrodermies pityriasiques en plaques disseminées*," with which it will be closely compared when the cases themselves have been considered.

A case which I showed at the Dermatological Society of London in October, 1904, when Drs. Hallopeau, Gastou, Jacquet and Pautrier were present, was not regarded by them as a case of Brocq's disease, with which they were presumably familiar, but as an entirely new affection in their experience.

The following description is drawn up from nine of the cases, all males, which, in the main features, closely resemble each other. The remaining case, a lady, had some important differences which will be discussed later.

So far, all the cases have been adults, though some of them were young. The lesions are evolved in patches of a pale pink or yellowish hue on the limbs and trunk, the uncovered parts, such as the face and hands, being free or very slightly affected. Generally, the patches come out very gradually and in small numbers and, in the main, symmetrically, but as the older patches never go away spontaneously, while fresh ones are continually evolving at short or long

intervals, large areas are involved, and in the course of years (in one case, months) the whole trunk and limbs are crowded with lesions, though there are always spaces of normal skin intervening, or sometimes completely enclosed by the diseased process, where the original patches have coalesced. For the most part the original patches are discrete and enlarge but little after their formation, unless they merge into adjoining patches, when hand-sized or larger areas may be formed.

With regard to individual patches, they are usually of oval or elongated form, arranged symmetrically in oblique lines on the back in the direction of the ribs, probably in the lines of fission, more or less horizontal in direction in front, and often, but not always, in vertical lines on the limbs. On the latter, especially the thighs, they not infrequently present the appearance of streaks formed by the finger, the upper part of the stroke being abrupt, and the lower shading off. This may sometimes also be seen on the trunk. The majority of the single patches range from one to three inches in their longest diameter; the borders are not very well-defined nor raised above the rest, but there is no difficulty in discerning the morbid from the healthy skin. They are not raised above the surface; but may be rather deep in the cutis. Infiltration can often be distinctly felt when the patch is pinched up in comparison with the adjoining healthy tissues, but in the more recent and smaller patches it is imperceptible, and occasionally they look like mere stains. Their colour is either pale pink or yellowish; in some cases the yellowish hue is pronounced, in others absent or nearly so; on the lower limbs the pink hue predominates. The surface is smooth on the trunk, but is often slightly rough on the arms and thighs, and below the knees may be distinctly rough or even in branny scales. The patches are never so marked on the upper as on the lower limbs, the palms are always free, and the backs of the hands are generally unaffected, but sometimes there are a few small patches below the wrist. The face is nearly always free, though I have seen faint patches in one case. There is very little to suggest that the disease is inflammatory, and itching is quite absent in most of the cases; a few patients said they had some itching when hot, but only in one case was it really complained of, and that only in the early evolving stage of the patches. The initial site for the lesions varies; the thighs are the most frequently first affected, the legs next in frequency, and

then the trunk. The lower limbs, too, are generally more crowded with lesions than other parts.

The duration of the disease may be very long. My first case had been developing for over ten years, others had been only for a few months; but in the case of a medical man, over 50 when I saw him, he said that patches first appeared on his legs when he was a house-surgeon, and had been slowly evolving ever since, so that after thirty years he was pretty thickly covered, as none as far as he knew had gone entirely away, though they had temporarily disappeared when he had rubbed in chrysarobin ointment, but had gradually returned to their old site.

The disease is compatible with perfect health; and even when there was any departure from the normal there was no reason to suppose that the abnormality was in any way connected with the skin lesions, while the majority of the patients had above the average health for their age.

While there appears to be no tendency in the disease to spontaneous involution, they are not, as the case narratives show, altogether rebellious to treatment, and in at least two cases a cure appears to have been effected and in others some improvement, while in a residue no improvement could be noted. The agents which appeared to have a good effect are salicin in 15-grain doses at least three times a day, which by itself entirely cured a recent case (Case 5) of only two months' duration and of rather acute development, and vasogen iodine 10 per cent. rubbed in is a useful supplement and materially aided in the cure of Case 4. In some cases, salicin has failed to make any marked impression on the lesions, while in others the patient has not gone on with it sufficiently long to test its merits. As might be expected, it has been most successful when the disease has been present for a short time.

The only female case, a lady aged 47 years, resembled the other cases in its gradual evolution, long duration, absence of itching, in the persistence of the old patches with continual evolution of new ones, in its limitation to the covered parts, and in the general good health of the patient. The differences were in the patches being distinctly scaly all over the body; though the scales were small and even powdery in most parts of the body, they were, as usual, rather larger and more abundant on the legs. The patches were also more decidedly red than

in the other cases ; while there was some spontaneous improvement in the summer, in winter the patches cracked and smarted. This patient, who had been affected with the disease for ten years, had had the most varied drug and spa treatment, including eucodylate of soda injections for three months without any material effect ; but after nine exposures to the Röntgen rays, the part exposed entirely cleared up, while the disease was unchanged on the inner side of the leg which the rays had not reached. I intend, therefore, to make use of the rays wherever practicable.

As regards *etiology*, it is chiefly negative. There is a large preponderance of males, and all the cases have been over 20 years old, while 56 years is the oldest I have met with. In no case could an exciting cause be made out ; two of the patients had had syphilis, but it did not appear to have any etiological importance, and in one of them antisyphilitic treatment was tried vigorously for twelve months without effect.

CASE 1.—Mr. O—, draper, aged 30 years, was first seen by me on March 5th, 1902. The disease had been present ten years. From the commencement none of the patches had gone away. They appeared simultaneously inside the arms and thighs. They increased in numbers very slowly for a long time, and were confined to the limbs until three years ago, when they attacked the trunk, and during the last year have greatly increased in number ; in fact, most of them have appeared in the last twelve months. His father was drowned and his mother died of fatty heart at the age of 51 years. When first seen by me the disease was in yellowish patches which commenced four inches above the nipples, but were not abundant till the line of the nipples, and they were less numerous below the umbilicus than above it. They were rather thickly arranged in horizontal elongated patches from 1 to 3 inches long, and $\frac{1}{2}$ inch wide, as if streaked by the finger, pale, pink, or yellowish in tint, rather well-defined, but the edges were not sharp, and when the patch was pinched up a slight infiltration or thickening could be felt in the skin. The longer patches were formed by coalescence of some of the smaller ones. The surface was quite smooth. On the sides, the patches inclined slightly downwards and forwards, but they were practically horizontal in front. On the back they were sparse, and faintly developed in the interscapular region,

and not nearly so numerous as in front; but on the lower half of the back and sides they were in the form of yellowish red stains, without elevation or roughness, and they were more numerous than on the upper part of the back. Forearms: The patches were on the inner side chiefly, more numerous on the right side than the left, and thickly arranged between the wrist and elbow. They were not elongated, but roundish, oval, or irregular, about three quarters of an inch in diameter, and somewhat brighter in tint than on the trunk. The surface was faintly rough, and on pinching up a patch it was slightly thicker than usual. There were about eight to ten patches on the right upper arm, while the left was almost free, and there were not nearly so many patches on the left forearm as there were on the right. On the thighs: They were most abundant on the inner side, and many more on the right side than on the left. There were scarcely any patches on the front of the thigh, but there were a few on the outer side. The patches sloped downwards and inwards, were oval and broader than the trunk patches, but still like finger-streaks. The legs were much more densely covered with coalesced irregular patches, some enclosing healthy skin, and the surface was rougher than the lesions on the rest of the body. On the neck, there were a few ill-defined spots about one inch square in area. There was slight blotchy redness of a not very obvious kind on the face, scarcely perceptible on the forehead. There was some *seborrhœa capitis*, but not so much as formerly, as he uses brilliantine. The patches seldom itched unless he got very hot. No illness preceded the eruption; in fact, he has never had any illness; his tongue was clean, and he looked and has always been perfectly healthy. The general aspect was somewhat that of a general orbicular *seborrhœic eczema*, except that for the most part the surface was smooth.

He has consulted dermatologists and others, but nothing he has taken or used has done him any good. I only saw him once.

CASE 2.—Mr. H—, aged 37 years, manager of a factory, came to me on April 2nd, 1902. His general health was very good. The disease had been present five years, and began on the right fore-arm and a little later attacked the left. He has never been free since it first appeared, but thinks some patches have faded and others come out. In the last winter he had been decidedly worse, for the patches had

certainly increased during the last few months. On the fore-arms, they were nearly symmetrical, and were quite so at an earlier stage. The lesions were yellowish or pale red patches; the simple ones were elongated, but the compound ones irregular in outline; they were from $\frac{3}{4}$ to $1\frac{1}{2}$ inches long. The surface, with a lens, could be seen to be very slightly roughened, but this was not perceptible to the finger—but when pinched up there was decided thickening, though they were not raised. There were no patches on the back of the arms or fore-arms and none on the trunk, but there were similar patches on the inside of the thighs and on the legs, some of them larger than the arm-lesions but less distinctly patchy. There was a large, irregular area on the back of each thigh, and a few roundish ones scattered about the limbs. The face was quite free, there was no seborrhœa capitis and there was no itching or other sensory symptoms in the patches. He was one of ten brothers and sisters who were in good health, except one who died of syphilitic paralysis. His father died aged 71 years, and his mother, aged 63 years, was alive and well. He was given salicin, gr. xv *ter die*, and a lotion of glycerine of lead and liquor carbonis detergens. I saw him again on July 3rd, when the eruption had cleared up considerably, much of it having faded, leaving only a slight stain, but here and there it was still yellow and slightly rough. He was much better when he took the medicine regularly, but when he stopped it some of the eruption returned. The salicin was increased to 20 grains. I did not see him again until July 23rd, 1904. He then said he took the medicine for three months from July 3rd, 1902, and then stopped it. He had used the lotion a little longer. On the back of the legs there were large patches nearly covering the entire area, but not much in front. It was more distinctly red here than elsewhere, and there was very little thickening. There were only one or two patches on the left thigh, but a dozen or more on the right. The trunk still remained free. The initial patch was on the right wrist seven and a half years previously, but had disappeared. Some few fresh ones still developed occasionally. He was told to continue the salicin and rub on 10 per cent. vasogen iodine.

CASE 3.—Mr. H—, aged 56 years, butcher, came to me with skin lesions of which he had only been aware three weeks, but they may

have been there longer as he had to get up so early to attend the markets that he rarely saw his own skin. He was a stout healthy-looking man, but he had syphilis in 1879 and had then suffered from iritis; he was under treatment for two years. He suffered from constipation and had done so since he had enteric fever as a young man. Urine had no albumen nor sugar. He came of a long-lived family, his father having died at 86 and his mother at 74. He had seven brothers and sisters alive out of thirteen. The lesions were few in number and situated symmetrically over the lower ribs on each side, the patches sloping obliquely downwards from the back to the front. One on each side was 6 or 7 inches long and compound. There was a single one much smaller (2-3 inches) symmetrically situated in a line with the large patch, and there were three or four others above the major patch on the back. There was one distinct patch over the left scapula and about half a dozen fainter ones about the back; a few faint ones were present on the back of each arm and forearm. The lower limbs were free. The patches were erythematous in aspect, the larger ones brightish red, the others paler. The surface was very faintly roughened to the touch, and there was very distinct thickening when the skin was pinched up, but they were not raised above the surface. The borders of some of the patches were well defined, while others shaded off gradually.

He was given salicin internally and, to rub in, 10 per cent. vasogen iodine.

On February 11th there was decidedly less thickening on the left side but no noticeable difference on the right. He complained of indigestion, so the salicin was stopped and bicarbonate of soda given him, with tincture of *nux vomica*. On March 17th the thickening was much less and the patch on the left forearm was gone. On May 8th it had all cleared up and only left slight staining. As he has not come again he has probably remained well. The resolution of the patches was in this case probably, to be chiefly attributed to the vasogen iodine.

CASE 4.—Mr. M—, aged 54 years, a gentleman in good circumstances, was brought to me on June 2nd, 1903, by Dr. Lovell. All his family were long-lived. His grandfather was killed by an accident aged 93 years, but his father died of cardiac disease, aged 67 years. The disease the patient suffered from commenced early in April, *i.e.*

two months before I saw him, on the right leg, and by June had extended all over the lower limbs and on the trunk, nearly all over the back, but there was scarcely any on the front. On the forearms, the patches were more on the extensor than the flexor surface. The eruption consisted of irregular, pale, erythematous patches from a square inch to the palm in size, with distinct infiltration in most of them. On the back, they were arranged symmetrically in the direction of the ribs, *i.e.* sloping downwards and forwards from back to front. In the early stage, on the back, they could be traced to commence as minute papules at the hair-follicles, and gradually the intervals between were filled up until infiltrations with a uniform surface were formed. Some itched, but none severely, and many did not itch at all.

Salicin 15 grains three times a day, with 5 minims of tincture of nux vomica, was prescribed. On June 23rd I saw him again, and there was then distinctly less thickening on the thighs and legs and the eruption was somewhat less bright in some parts. The longitudinal patches over the scapula were still thickened, but there was less infiltration in the patches on the upper limbs and on the forearms they were yellower.

In response to my inquiry Dr. Lovell wrote me on November 29th, 1904, that he saw the patient on July 19th, 1903, and the eruption appeared to be gradually fading away. He next saw him for a sore throat in January, 1904, and the patient told him that the skin affection had gradually left him. He had had no other treatment than taking the salicin which I prescribed. This case is the most satisfactory and rapid in its involution under treatment, as it was also the most rapid in its evolution, and came earlier under my observation than any of the others.

CASE 5.—Dr. D—, aged 53 years. In 1876, while a house-surgeon, he first noticed a patch on one calf; since then the patches have gradually increased in number, and some of them in size. Chrysarobin kills them down for a time, but they re-form in the same place. In his family history a sister died of Addison's disease, and one daughter is slightly phthisical. His own health is good and he is well nourished.

When seen by me on February 4th, 1904, there was a large

irregular lesion occupying nearly the whole of the interscapular region and numerous others on the back, abdomen, and thighs. They were of a dull pale lemon colour; some were distinctly thickened when the skin was pinched up; in others this was not recognisable. On the thighs, they were pinkish and slightly roughened. On the body they were smooth, elongated, oblong, oval, and well defined, symmetrically placed, and on the back in oblique lines sloping down and out from the spine in the lines of cleavage, *i. e.* corresponding to the rib slope. They seldom itched or gave any trouble.

CASE 6.—Mr. H—, aged 37 years, a draper. The disease had been present two years. When seen on April 26th, 1904, he had numerous patches on the calves and front of the legs, some three or four inches across, with distinct thickening. They were round, well-defined, and when pinched up were hard as compared with the adjoining healthy skin. Besides these there were more recent superficial irregular patches symmetrically arranged on both thighs. In the interscapular region and in front under the breasts were slightly yellowish stains, but no other alteration of the skin could be seen or felt, the surface being quite smooth. There was occasionally some itching, but never severe. There was constipation present, but no other symptom of ill health.

He was ordered fifteen grains of salicin three times a day, and to rub in ten per cent. vasogen iodine. He was seen again on June 1st, when there was less thickening in some of the patches, but no other change.

CASE 7.—Mr. D—, aged 34 years, was seen first on November 3rd, 1904, in consultation with Dr. Payne. He had had a chancre in 1896. He had a severe sore throat and a rash, which only lasted a short time. He was treated with mercury for eighteen months.

The present eruption began from three to four years ago, and for the last twelve months he had been treated by Dr. Payne with the biniodide of mercury mixture, $\frac{1}{16}$ grain three times a day, and also with mercurial inunctions, but without making any material effect upon the present lesions. When I saw him the trunk was only slightly affected. There were a few pale yellow patches below the nipples, elongated and nearly horizontal. On the back, there were one

or two commencing yellowish spots in the interscapular region, but in the lumbar and sacral regions they were fairly numerous, and also yellowish and elongated horizontally. On the thighs, the patches were very abundant in vertical elongated streaks about half an inch wide, as if the finger had been wiped down the limb in two- or three-inch pale yellow streaks. On the legs, the patches were larger, irregular in outline from coalescence, and of a yellowish-pink colour. The eruption was very symmetrical, many of them, especially on the thighs, were slightly but distinctly thickened when pinched up. On the arms and forearms there were a good many patches, but not so many as on the thighs, where, arranged in the line of the limb, they were of a paler yellow colour. The patient said that they itched very decidedly almost always at night and very often in the day. Sometimes they were sore. They did not itch when they first came out. The eruption began on the thighs, and although fresh ones were coming out from time to time, none, so far as he knew, had faded or gone away.

He was ordered to rub in vasogen iodine and take salicin 15 grains three times a day. I heard about two months later by letter that there was no material change, but he had not used the iodine local application.

CASE 8.—Charles C—, aged 32 years, tailor, came to University College Hospital on October 4th, 1904. He stated that the skin lesions had commenced four years previously, appearing first on the thighs, then on the legs, and a little later on the forearms. He did not remember when the body was first affected. Fresh patches have appeared from time to time, but none have gone away. The lesions consisted of irregular patches from half to several inches in diameter symmetrically distributed over the trunk and limbs. On the back, they were in elongated or oval patches, symmetrically arranged in oblique lines corresponding to the direction of the ribs. They are well defined from the healthy skin, not raised above the normal skin, and the border was not raised above the central portion either to sight or touch. In front, there were large areas due to coalescence of several patches, but the smaller patches were elongated and horizontally placed. On the thighs near the groin the patches ran obliquely round the limb, but lower down were vertical. The general colour was yellowish pink, but in some the yellow, in others the pink predominated. When

pinched up, many of the patches were distinctly thickened, but in the more recent this could not be felt, and some appeared as mere stains. The surface was smooth on the trunk, but on the lower limbs there was some roughness of the surface, more marked below the knee, but not actually scaly. The patches on the trunk were larger than on the limbs, and healthy areas of skin were sometimes completely enclosed by the diseased patches. The upper part of the chest, neck, and face were free, except a small patch on the lower lip. There were also large spaces of unaffected skin on the thighs, but only small ones on the upper limbs. On the back of the hands near the wrists, there were some small patches. The mucous membrane of the mouth was normal. There was no itching nor other subjective sensation. There was a history of phthisis in his mother and brother, but the patient was well nourished and healthy, except that he was liable to bronchitis, and had some enlarged post sterno-mastoid glands on the left side. He was put upon salicin gr. xv *ter die*, and vasogen iodine rubbed on the forearms, but so far no decisive result has been obtained. Mr. Pernet has obtained a piece of skin from the right forearm, where the lesion was apparently superficial. His report is appended.

CASE 9.—A gentleman, aged 29 years, in whom the disease has been present for four and a half years, was seen with Mr. George Pernet, who showed him at the Dermatological Society of London in November, 1904, and the notes of his case were published in the December number of the *British Journal of Dermatology*, vol. xvi, p. 457.

There remains only the case of the lady, which requires separate consideration.

CASE 10.—Mrs. H— was sent to me by Dr. Vassie on January 18th, 1902. She had suffered from the disease for nine or ten years, had seen other dermatologists, and visited sulphur and other spas. The disease had begun with a single patch on the arm, and after remaining single for a few months, had spread and extended almost all over the body and limbs.

When I saw her, the lesions were practically all over the trunk and limbs with ill-defined pale red patches with powdery roughness and

decided thickening of the whole cutis of the patches, most marked in a 3-inch patch, situated high up on the right loin. The thigh patches were also thickened, but on the arms and forearms the thickening was less marked. On the front of the legs, the patches were irregular and more decidedly scaly, but not like either eczema or psoriasis. The eruption, as a whole, was like a seborrhoic eczema but less defined, and in parts the lesions were very pale and shaded off into the healthy skin. The neck, face, and hands were free. It smarted in cold weather, but did not itch.

The catamenia were regular, and her general health when seen was excellent, but a year previously she had had a fibroid removed after it had begun to be troublesome for a month from hæmorrhage. Before that the catamenia were twice a month. There was slight seborrhœa capitis. Salicin, 15 grains three times a day, was given. On July 17th she was seen again, and the eruption on the legs was somewhat paler, and that on the arms was much paler, but over the scapula the lesions were thickened but paler; but she attributed the improvement to the warmer weather during the last month, as there was generally some improvement in the summer, while in the winter it fell back, cracked, and smarted. She was not seen again until May 12th, 1904, having meanwhile had other advice, but without any improvement, and none of the patches had gone away. At Wiesbaden she had subcutaneous injections of cacodylate of soda in the month while she was there, and once a fortnight for twelve weeks after, but without benefit. It was noted that the legs were distinctly red and scaly. On the rest of the limbs and body the patches were red and scaly but without thickening, except on the forearms, the patches on the left being distinctly thickened. The patches were large, many being palm-sized and in the aggregate covered three fourths of the body, but the face and hands were quite free, and the neck nearly so. There was no itching. As every previous treatment had failed, the possibility of the disease developing into Mycosis fungoides being entertained, although itching was absent, it was resolved to try the effect of the Röntgen rays on a portion of one leg. Nine exposures of ten minutes each at a distance of eight inches were given, and a month after there was slight improvement where the rays had been used, but it was not very decided; but on the left arm where vasogen iodine had been rubbed in there was decided improvement, the lesions being

pale, less scaly, and there was some clearance as compared with the right side, which had not been treated. I did not see her again until February 7th, 1905, and she then told me that the improvement where the X-rays had been applied had continued, and in a few weeks after I last saw her, in August, 1904, the disease had entirely disappeared from the outer side of the leg below the knee, and the skin when I examined it was quite white and smooth on the part exposed and had been so for four months, while the inner side of the leg where the rays had not reached remained unaltered. She had not continued the vasogen iodine to the arm, and it had become scaly again.

General Remarks on the Disease.

From the above description and the cases related in support of it, what inference may be drawn as to the nature of the disease and its relation to other skin affections? Frankly, at present I am quite unable to even conjecture its pathology, or to suggest, with one exception, any relation to other dermatoses. In my first cases I supposed that it was an early stage of Mycosis fungoides, though the absence or trifling character of the subjective symptoms did not lend this any support. I clung to this theory, however, *faut du mieux*, for a long time, but it received its *coup de grace* when I met with a case of over thirty years' duration without any such malign development.

At the Dermatological Society of London, where Mr. George Pernet and myself have shown three cases, among other suggestions, that of a possible seborrhœide or Urticaria pigmentosa have been made. Against the former, the absence of scaliness in a large proportion of the patches, that the patches are in the skin, not raised above, and that itching is an exceptional feature, together with the unchanging character of the lesions, effectually bar the diagnosis of a seborrhœide. Neither can I find anything beyond the yellowish tint frequently, but not always, present to support the idea of Urticaria pigmentosa. The absence of itching in nearly all the cases of Urticaria factitia, while the patches are level with the normal skin, and their unchanging character, are all strongly against such a diagnosis, to say nothing of the extreme rarity of adult Urticaria pigmentosa and the improbability of one man meeting with nine cases of it. The histology also negatives this.

I can therefore, at present, only regard it as a dermatosis *sui generis*, of which the pathology must be left an open question, as Mr. George Pernet's report on the histology of the portion of skin removed from Case 8 does not throw much light upon the pathology. There remains only the affection described by Brocq, to which, certainly, there are closer resemblances than to any other affection.

Brocq* divides the group which he calls parapsoriasis into three groups:

First variety (very closely related to psoriasis), Parapsoriasis guttata. Jadassohn's case is probably to be referred to it.

Second variety (intermediate between Lichen and psoriasis), Parapsoriasis lichenoides, including Parakeratosis variegata of Unna, and Lichen variegatus (Crocker).

Third variety (closely allied to Seborrhœa psoriasiformis), Parapsoriasis in patches, corresponding to Erythrodermic pityriasis en plaques disséminées of Brocq, and of which cases have also been reported by J. C. White and C. J. White.

It is only with the third variety that comparison need be made, the deep colour and very small pattern, like a mosaic of the first two, sharply contrasting with the broad effects as of colour dashed on, in Xantho-erythrodermia perstans.

For the whole group Brocq gives the following characteristics:

- (1) An almost complete absence of pruritus.
- (2) A very slow evolution.
- (3) A distribution in circumscribed, sharply defined patches, whose dimensions are from 2 cm. to 6 cm. in diameter, and which are scattered here and there over the integument.
- (4) An almost complete absence of infiltration of the derma.
- (5) A pale redness (pinkish coloured).
- (6) A fine pityriasic desquamation.
- (7) An extraordinary resistance to the local applications usually employed in the treatment of psoriasiform or pityriasic seborrhœa, in fact, only yielding slowly and imperfectly to the most energetic application of pyrogallic acid.

The special features of the third variety he describes as:

- (1) Being in patches, circumscribed, sharply defined from 2 cm. to 6 cm. in diameter.

* *Amer. Journ. Cut. Dis.*, vol. xxi, 1903, p. 315.

(2) They are scattered irregularly over the skin without any apparent system.

(3) The colour varies from a pale red to a brownish or livid red, according to the part affected.

(4) There is always present a fine pityriasic desquamation more or less marked in different cases.

(5) There are at times in some of these cases, aggregations of small flattened papules which may be considered as links connecting it with the second variety.

(6) There is no infiltration of the integument appreciable to the eye or touch.

(7) The face is rarely affected, and there is the same extremely slow evolution, great resistance to local treatment, and few or no subjective symptoms.

Referring to the whole group, he says: "We know nothing very definite about the etiology or pathology of these affections. They may appear at any age, but seem more frequent in youths or adults. He has observed cases in men and women and in all classes of society. They seem to be slightly more frequent in women than in men."

It must be confessed that there are many points of resemblance of this third variety to Xantho-erythrodermia perstans, and, as regards the lady, Case 10, it is probably what Brocq has described as "*Erythrodermie pityriastique en plaques disséminées*," although I should say there was distinct infiltration in a large proportion of the lesions, and many of the patches far exceeded the limits in size that Brocq lays down.

With regard to the other nine cases, the differences are somewhat more marked, and they should, at least for the present, be either kept apart or treated as a distinct variety.

The differences are:

(1) The patches are frequently much larger, 3 and 4 inches or more in their long diameter, and the margin is not very sharply defined.

(2) A distinct arrangement in lines in direction varying with the topography is observable in most cases.

(3) The colour is either pale red or distinctly yellowish.

(4) Instead of a fine pityriasic desquamation being always present, this is only distinct on the legs, sometimes just recognisable on the thighs and arms, while on the trunk it is absent, the surface being usually quite smooth.

(5) The presence of papules I have not observed, except at the commencement of Case 4.

(6) There is distinct infiltration in a large proportion of the patches, perceptible to the touch, though not to the eye.

The resemblances are: the absence of conspicuous pruritus, and there is often none; the occurrence in patches; the slow evolution; a pale redness; in many cases an extraordinary resistance to treatment. These are not enough to establish identity, but I confess that in my opinion they show greater resemblance to the affection I am describing than they do to psoriasis, and certainly my nine male cases would never suggest to any one a resemblance to psoriasis, and I should strongly demur to class them under parapsoriasis as a covering term.

Histological Note by George Pernet.

A piece of skin was removed from the extensor surface of the right forearm of the male case, aged 32 years (a Jewish tailor), where the more recent patches had appeared. Clinically there was practically no infiltration to be felt in that situation. The specimen was hardened in alcohol, cut in celloidin, and stained in various ways. The microscopical appearances were as follows:

Epidermis.—The stratum granulosum was either atrophied or absent. The stratum lucidum was absent except for traces here and there. The epidermis generally showed a slight amount of œdema.

Corium.—The vessels were dilated, with some cellular infiltration about them. The collagen appeared to be normal, with the exception of slight œdema, but the elastin was apparently reduced in quantity, especially in the papillary layer, and it was to some extent fragmented in places. It should be mentioned that the specimen was stretched on a small piece of cork in the process of hardening. The elastin stained, however, much as in the normal condition.

Altogether there was little to be gathered from the histology *quâ* cause, except that the appearances of the blood-vessels perhaps pointed to a general blood condition.

Dr. Thiele, Pathologist to University College Hospital, kindly examined the blood and reported: Total red corpuscles per c.mm., 6,560,000; total whites per c.mm., 21,878. Hæmoglobin, 84%. C.T., '65. Differential count of whites: Small lymphocytes, 18.2%; large lymphocytes, 9.4%; neutrophiles, 60.7%; oxyphiles, 1.6%; hyaline cells, 2.1%.

IDIOPATHIC MULTIPLE PIGMENT SARCOMA (IDIOPATHIC MULTIPLE HÆMORRHAGIC SARCOMA) OF KAPOSÍ.

By F. PARKES WEBER, M.D., F.R.C.P.,

AND

PAUL DASER, M.D.

THE patient, Jakob Z—, is a Polish Jew, aged 46 years, from Galicia, who has lived nine years in England, and says he has enjoyed good health. There is no evidence of previous alcoholism or syphilis. The patient was brought by Dr. Weber before the Dermatological Society of London on February 8th, 1905.

The present illness commenced about three years before, when he chanced to wound the sole of his right foot with a nail. A pedunculated growth, about the size of a cherry, arose from the wound. This description reminds one of the strawberry-like granulation tumours sometimes growing from small wounds or ulcers on the fingers, which have been termed "botryomycosis," or rather "botryomycomata," because at one time they were supposed to be caused by the "botryomyces."* The growth was removed by a doctor. Afterwards small bluish nodules developed from time to time on the feet and legs. Some of these nodules apparently undergo the following series of changes: They slowly increase in size, and after about

* *Vide* X. Delore, *Lyon Médicale*, July 16th, 1899, p. 376; J. Sabrazès and A. Laubée, *Arch. Gén. de Méd.*, Paris, November, 1899, p. 515; R. von Baracz, *Wien. klin. Wochenschr.*, 1901, No. 14; G. Carrière and G. Potel, *Presse Médicale*, Paris, May 17th, 1902, p. 471; and L. Legroux, "La Botryomycose," *Thèse de Paris*, 1904. The botryomyces appears to have owed its supposed existence to a mistaken interpretation of microscopic appearances. H. Bichat (*Arch. Gén. de Méd.*, February 2nd, 1904, p. 281) thinks there is nothing specific in the growths, but V. Ball (*Arch. Gén. de Méd.*, August 2nd, 1904, p. 1921) concludes that botryomycosis, though it owes its name to an error, is nevertheless a pathological entity and is a special staphylococcal affection. Dr. Weber possesses a microscopic section of one of these little growths, which was removed from the finger (close to the nail) of a woman in 1890, when he was a house-surgeon at St. Bartholomew's Hospital for Sir William Savory. It was a typical strawberry-like "botryomycoma" with quite a narrow pedicle. Dr. J. M. H. MacLeod, who has kindly examined the section in question, tells us he regards such growths as "septic granulomata," septic organisms producing very various effects according to their degree of virulence and naturally according to the nature of the living soil on which they grow.

three months constitute little pendulous tumours, which ultimately fall off spontaneously or else are knocked off or pulled off by chance; in this way local healing occurs, but fresh nodules form elsewhere. Though, as stated, some of the nodules become pedunculated growths, others appear to atrophy and merely leave brownish pigment in the skin, whilst others seem to undergo very little change, and, at all events, persist for a long time in their primitive form, namely, as hard bluish lumps under the epidermis. Treatment has been as yet without result.

Present condition (January, 1905).—On *the hands* about the knuckles and backs of the fingers are a few minute slightly elevated bluish nodules. On the sole of the *right foot*, especially on the inner part, there are nodules in various stages of development. The minute ones, those in an early stage of development, are slightly elevated and of a bluish colour, similar to those on the hands. Others, further advanced in development, are small, sessile, or pedunculated hard outgrowths, without bluish colour and sometimes covered by thickened epidermis. There is a large patch of pigmented (brown) skin on the dorsal surface of the right foot, and in the neighbourhood of this pigmented area are some minute nodules of similar character to those already described. It is possible that the pigmented skin has been the site of minute growths which have undergone spontaneous involution, and have, as frequently happens in Lichen planus, left pigmentation of the skin behind them. The right thigh and leg are not affected.

The *left lower extremity* is the part most affected by the disease, and there is chronic, rather firm, œdema of the left foot and ankle. The nodules on the left foot are similar to those on the right, but are more widely distributed, and the left foot differs from the right in the absence of the pigmented area and in the presence of the œdema to which we have just alluded. Of the little sessile or pedunculated tumours on the back of the left foot and in the neighbourhood of the ankle-joint (see Fig. 1) the biggest are of the size of a large pea. There are likewise little tumours of various sizes—that is, in various stages of development—on the inner aspect of the left popliteal region (see Fig. 2) and in the neighbourhood of the patella, the smaller ones being bluish and slightly elevated, the larger ones being reddish, lentil-sized, sessile outgrowths.

There are no nodules or growths on other parts of the limbs, trunk,

or head, with the exception of four or five minute purplish or bluish papules on the *glans penis* and neighbouring skin.

There is no evidence of any disease of the thoracic or abdominal viscera. The patient is not strongly built, but looks well nourished.

FIG. 1.



He complains of various pains, but whether these are related to the disease or not is doubtful.

Microscopic examination.—One of the growths, of the size of a large

FIG. 2.



pea, was removed from the left ankle, and a smaller one (lentil-sized) from the left knee. Sections of both were stained with hematoxylin and eosin-hematoxylin. The growths are seen to be situated in the corium, and are circumscribed. The epidermis over one of them is thickened. They consist of oval and spindle cells,

which, in some parts, are more or less grouped into strands or bundles, and are cut in various directions. In some parts of the sections there are empty spaces (? lymph spaces) and in some parts there is homogeneous substance between the cells; in other parts there is extravasated blood. The cells in the larger and older of the two nodules are decidedly more elongated and fibrous-looking than in the smaller and more recently developed one. Dr. J. M. H. MacLeod is kindly going to make a further report of the microscopical features.

Remarks.—It seems to us clear that the case is a typical but relatively early one of the so-called idiopathic multiple pigment sarcoma (idiopathic multiple hæmorrhagic sarcoma) of Kaposi and later writers. For the literature on the subject we refer to the English summaries of Dr. J. H. Sequeira* and Dr. Radcliffe-Crocker.† The patient in our case is a male, as in nearly all other recorded cases of this disease; he is of the favourite age (between 40 and 50), and it may likewise be noted that he is a Galician Jew, as the patient of Sir Stephen Mackenzie‡ and Dr. J. J. Pringle was. The minute bluish nodules in the corium may be regarded as the primary feature of the disease. They either remain for a long time without undergoing much obvious change, or they undergo spontaneous involution and completely atrophy, leaving behind them only a little brownish cutaneous pigmentation; or else (thirdly) they may increase in size, become much elevated, and form definite sessile tumours, which, later on, become pedunculated, and finally drop off. This is the cycle in regard to the development of the little pendulous tumours which constitutes one of the most characteristic features of the disease. Another characteristic feature of the disease, probably sooner or later present in every case, is the œdema which occurs in the parts most affected, especially in the lower extremities. It is persistent œdema, and results in an elephantiasis-like condition. It is well marked in the left foot and ankle of our case. The striking blue or purple colour of the small nodules (which is absent in the pendulous tumours) seems, as in other cases, to be due to the venous blood contained in the blood-vessels or extravasated. What pigment there is

* *British Journal of Dermatology*, June, 1901, p. 201.

† *Diseases of the Skin*, third edition, 1903, p. 963.

‡ *British Medical Journal*, June 4th, 1890. Amongst foreign accounts *vide* Radaeli's report of five cases in *Lo Sperimentale*, December, 1904, p. 1023.

in the growths is probably derived from blood. In our patient there is no evidence of gout as in certain cases described by Mr. Hutchinson.*

The prognosis in the present case is not altogether unfavourable, considering that the patient's general health is good, that the disease is probably seldom of itself fatal, and that in some cases improvement or spontaneous cure has, apparently, occurred after the disease has lasted twenty years or more.

SOCIETY INTELLIGENCE.

THE DERMATOLOGICAL SOCIETY OF LONDON.

AN Ordinary Meeting of the above Society was held on March 8th, 1905, at 5.15 p.m., Dr. J. H. STOWERS in the chair.

The following cases were demonstrated:

Dr. JAMES GALLOWAY showed the case of a young lady presenting an eruption on the left arm of unusual character. The lesion in some respects resembled those of granulomatous origin, but no definite diagnosis was given. This case will be subsequently noted in full.

Dr. T. J. P. HARTIGAN (introduced) showed a case of *atrophy of the nails*, a description of which will be found on page 147.

Dr. GRAHAM LITTLE showed: (1) A case of a *corymbose syphilide* in a man aged 44 years, with a history suggestive of a double infection with syphilis. The patient had been in the Army and had contracted syphilis in India, twelve years ago. He then had a chancre on the top of the glans penis, the scar of which was still visible. He was taken into the Military Hospital and treated for exactly ninety-seven days, his treatment ceasing entirely after this period.

* *Archives of Surgery*, vol. v, p. 237, and vol. vi, p. 132. See also Mr. Hutchinson's *Smaller Atlas of Clinical Surgery*, Plate 61, where he refers to the case figured by Hebra and Kaposi as "Sarcoma melanodes"; also his remarks on "Sarcoma melanodes" in the *British Medical Journal*, January 7th, 1905, and the case shown by him at the Polyclinic in December, 1904, which was also shown by Dr. Ormerod at the Dermatological Society of London, July 8th, 1903.

He had no secondary eruption and no further symptoms. Eight years later he had another chancre, also on the glans penis, but near the frænum. This was, according to his description, a deep ulcer, which was seven weeks in healing. He had no bubo following and no secondary eruption. Ten weeks ago he began to have the present eruption, which was the only general rash he had ever had. With the exception of the treatment during the actual presence of the two chancres, he had had no specific treatment whatever.

The eruption as seen on exhibition consisted of numerous groups of fairly large papules arranged in a somewhat herpetiform manner, with here and there a central larger papule surrounded by smaller ones, in the manner described as corymbose, but for the most part the groups were composed of papules equal in size; these groups were scattered over the back especially, the chest, the arms, the thighs, and the face, with individual large papules here and there upon the arms and legs. The mucous membranes were not affected.

The history seemed to point to a double infection, the interval between the two chancres being eight years.

(2) A case of *dermatitis artefacta* in a young lady, a private patient, who gave the following history. She was bitten by an old collie dog twenty-three days ago on the calf, through her dress. She was not seen by a doctor until a week or more later, and when seen by him she had a circular "patch upon the calf of vesicating erythema, surrounding the bite, with a vivid erythematous non-vesicating ring, about half an inch broad, surrounding the central patch, and separated from it by an intervening band of healthy skin, about a quarter of an inch broad." Four days later an exactly similar condition was noted on the lower part and inner aspect of the same leg, "a patch of vesicating erythema the size of a florin, surrounded immediately by healthy skin and then a ring of vivid erythema half an inch wide." The patient did not appear to be in any way neurotic. There was no apparent animus against the owners of the dog, who were old and intimate friends, and no breach of relations between them had taken place. She led a healthy active life and was, in fact, in robust health at the time. The ointment used in the first instance was obtained from a chemist; her doctor had prescribed carbolic ointment. The method of production was not ascertained and no adequate motive could be assigned.

(3) A case which was shown as *syringomyelia* with trophic ulcers on the upper arm and shoulder in a woman who had been under Mr. Ernest Lane's care for about twelve years, and had had numerous operations performed for a continually ascending necrosis of bone accompanied by trophic ulcers on the skin.

Some divergences of opinion were expressed as to the diagnosis, and this being at any rate a rare and interesting case, a more detailed report will be subsequently submitted for publication in this journal.

Dr. J. M. H. MACLEOD showed a case of *grouped comedones* associated with acneiform lesions on the chest of a boy aged 2 years. The comedones were present chiefly on the sternal region, but several isolated groups occurred around the nipple and umbilicus. Only a few of the comedones had become inflamed or transformed into acne pustules. The mother had noticed the comedones about a month before exhibition. There was a definite history of local irritation in the case, for since the child was a few months old he had worn a piece of flannel over the chest in the affected region, and as the mother believed that he had a delicate chest the flannel had been frequently saturated with camphorated oil. The exhibitor intended to make a bacterial examination of the lesions with the object of trying to find the acne bacillus, and hoped to report the result at a subsequent meeting of the Society. Another point of interest in connection with the case was the fact that it occurred in a boy, as the large majority of reported cases have been in boys. Dr. MacLeod referred also to another case in an infant boy of about a year old, which he had seen on the afternoon of the meeting, but unfortunately had been unable to bring up, in which the comedones were grouped on the forehead and cheeks and in which there was no history of local irritation to account for the lesions.

Mr. MALCOLM MORRIS showed a case of early *Parakeratosis variegata*, a full report of which will be published in a future issue of the journal.

Dr. ORMEROD showed: (1) A case of *Lupus erythematosus telangiectodes*. The patient was a woman, aged 44 years, who stated that she had suffered from an eruption on the cheeks for the last eighteen months. On exhibition, there was a large red area situated symmetrically on either cheek, the redness being due to dilatation of

the small vessels. Within these areas there were islets of paler and shiny skin, which showed superficial atrophy. A small area in each patch was covered with a crust which was difficult to remove, and when detached showed little tags and prominences on the under surface. The appearance of the eruption had not materially altered since the patient was first seen fourteen months ago.

All the members present agreed with the diagnosis of the exhibitor.

(2) A woman, aged 38 years, suffering from a curious *eruption associated with obscure nerve symptoms*. The history showed that four years ago she had suffered from some chest affection, accompanied by the expectoration of blood and offensive matter. She was ill three months, and during her convalescence she scratched her right thumb, and a lymphangitis of the arm, with axillary abscess, resulted. She next developed a painful swelling of the right elbow, which was opened and drained, and she thought a piece of bone came away; the arm was put up in splints. The right elbow had been stiff since that time, and during its healing she had developed pricking sensations in the fingers, which became contracted. There was then an interval of nine months' good health, after which, two years ago, she developed an abscess in front of the right thigh, which eventually broke, and laid her up for four months. Subsequently, about eighteen months ago, the rash appeared, at first round the site of the abscess, then spreading towards the buttock and loin, and finally extending down the leg.

On exhibition, the patient showed an extensive anæsthetic area over the right side extending up into the axilla, curving down both in front and behind at the level of about the sixth rib, and embracing the whole of the right arm and leg, with the exception of small islands on the palm, sole, and gluteal region, where sensation still persisted. The rash followed a similar distribution, but did not affect the arm, and tailed off on the leg with the appearance of isolated spots. The rash developed, according to the patient's history, in the form of red spots, on which a blister full of clear fluid formed. The fluid then became mattery, and an ulcer resulted. The development of an ulcer was heralded by a pricking sensation. On exhibition, the striking characteristics were the presence of patches of excoriated skin and white scars, surrounded by pigmentation. The patches were oval in shape, with the long axis running down the limb or transversely on

the trunk. The more recent lesions consisted of red, raised papules with an excoriation on the summit. In spite of bandaging with boric acid ointment in the hospital a few lesions formed beneath the dressings, though more appeared outside. Examination of the supposed affected joints showed nothing abnormal; the reactions of the atrophied muscles to electricity were also normal. The anæsthesia was shown to be of psychical nature, and the exhibitor therefore considered most, if not all, of her disabilities to be of an hysterical nature. He asked the opinion of the Society as to the nature of the eruption.

Most members, including the exhibitor, considered that the eruption was artificially produced by the patient.

Dr. J. J. PRINGLE showed a case of *Lupus erythematosus associated with Raynaud's disease* in a highly neurotic woman, aged 44 years. The symptoms of Raynaud's disease apparently first manifested themselves in 1895, but were first recognised as such in 1896. Associated with the typical phenomena of recurrent local syncope and asphyxia of the extremities, more especially of the hands, there were attacks of severe gripping abdominal pain. The exact nature of these attacks had never been accurately determined, but there were evidences of some chronic intestinal obstruction, which could not, however, be located. The exhibitor had witnessed several occurrences of typical Raynaud symptoms in the hands, and the nutrition of all the fingers was impaired, their tips being stumpy and atrophied, but no gangrene had ensued. The first manifestations of *Lupus erythematosus* showed themselves in 1900, in the temporal regions and scalp. They were regarded as "gouty psoriasis," and were treated by a physician professing the cult of homœopathy by repeated painting with pure oil of cade (!), under which they progressed rapidly, but in the wrong direction. She was also advised to winter in a high, cold, and dry locality, but she suffered terribly from this experience, which was carried out last winter in Switzerland.

The *Lupus erythematosus* was of severe inflammatory type, and occupied a great portion of the scalp, denuding it of hair, and giving rise to a large atrophic scar which was the seat of peculiarly obstinate recurrent attacks of suppuration, probably referable to a dirty toupet, worn for cosmetic purposes. Symmetrical patches were also present behind the ears, inside the pinnae, and in the zygomatic

regions, while there were present over the whole face a large number of telangiectatic spots averaging nearly the size of a pea. The nasal and buccal mucous membranes were healthy. The urine contained neither albumen nor blood-pigment, nor was there any history pointing towards hæmoglobinuria. The exhibitor asked the experience of members as to the value of treatment of such a condition by Finsen's method, X-rays, and especially by high-frequency currents, which he was inclined to try as of possible value in both the associated conditions present.

Dr. Pringle's suggestion, that treatment by high-frequency currents afforded the best prospect of benefiting the patient, especially with regard to the Raynaud phenomena, was generally accepted.

Dr. DORE was of opinion that the disease would thereby be considerably ameliorated and possibly even arrested, but the attitude of the majority of members present was somewhat sceptical.

Dr. H. RADCLIFFE-CROCKER showed a case of *tuberculous gummata* (or gummatus tuberculides). The patient was a well-grown and well-nourished, healthy-looking girl, aged 18 years, who first came under observation on February 17th, when the following notes were made: The disease began at the age of 7 years, when a crop of lesions made their appearance. One of these occurred on the abdomen, near the right ilium, where a large scar, about 3 inches (over 7 centimetres) in diameter, was present. This condition lasted for a few months. Then very few lesions appeared up to the age of 15, when they became more numerous and had gone on ever since without any interval of freedom. For three years the patient had been subject to flat circumscribed infiltrations of the skin varying from a shilling to a crown in size. These lesions all broke down more or less into superficial ulcers, which healed in from two to three weeks. On the legs and thighs up to the crest of the ilium there were a large number of more or less circular scars varying in size, but most of them about as large as half a crown (3 centimetres). On the thighs, however, some were over 2 inches in diameter (about 5 centimetres). On the right thigh near the knee there was a recent lesion (two weeks old), which was about $2\frac{1}{2}$ inches by 1 inch (6 centimetres by 2 centimetres), dull red, with great thickening; it presented on its surface a pea-sized ulceration, which had formed within twenty-four hours of the time when the patient was first seen. A similar lesion,

with a more advanced ulceration, on the right calf, had been present three weeks. Below the left knee there was a flat infiltration, slightly raised and well defined, about the size of a shilling (about 2 centimetres). On the right temple there was a small circular scar of $\frac{1}{4}$ inch, which had resulted from a similar lesion to those already described. The patient's lungs were unaffected, but the history was strongly tuberculous on the father's side, a large number of his relations having died of consumption, whilst some others were dying of the same disease at the present moment. The patient had lost one sister, aged 21 years, of phthisis, and a brother and another sister of "consumption of the bowels."

Dr. SEQUEIRA showed a case of *Lupus vulgaris* to illustrate the value of Dr. A. E. Wright's recent work upon opsonins. The patient, a Jewess, aged 20 years, was first seen at the London Hospital in the summer of 1900. The whole of the face and part of the neck were then much infiltrated and in parts ulcerated. The feet also were affected, parts of several toes having been destroyed. Owing probably to the fact that she was unable to walk, the patient was not seen again until February, 1905. Fortunately, photographs of the condition in 1900 were preserved, and these showed that the disease had extended very little in the four years and a half, although the patient had had no treatment whatever in the interval. The general health had improved, but the lupoid infiltration of the face and neck were well marked and there was still considerable ulceration, the ulcers being covered with dirty scab. The destructive ulceration of the toes had slightly increased. There were no physical signs pointing to tuberculosis of the internal organs. The glands were slightly enlarged, but this was not a marked feature.

Dr. Sequeira took the patient into the hospital, intending to use tuberculin. Before doing this, the blood was examined by Dr. Wm. Bulloch, who found that the opsonic index was 1.3, normal blood being 1. A high opsonic index, it may be mentioned, has been found by Dr. Bulloch in a certain proportion of the cases of *Lupus* attending the London Hospital, and particularly in the chronic cases doing well under the light treatment. As the opsonic index was already high in this case, it was deemed unnecessary to raise it by the injection of tuberculin, and fomentations were applied to the affected areas, to bring

the opsonins to the diseased parts. The result was very striking. In a few days the lesions were paler, flatter, and clean. When shown at the meeting, after a fortnight's treatment with fomentations, the infiltration had markedly diminished, the raised margin being flatter and paler, and the ulcerated areas healed up, except upon the stumps of the toes.

The fomentations were of boracic lint soaked in hot water and covered with oil silk frequently changed. It may be mentioned that the improvement was much more rapid than had been seen in similarly extensive cases treated by fomentations, the only known difference being the high opsonic index. The case is of importance as supporting Wright's work, and also as showing the value of examining the blood before injecting tuberculin. It also explains why some apparently severe cases do well under simple treatment.

Dr. GRAHAM LITTLE was able to confirm Dr. Sequeira's observations in this case from one at St. Mary's Hospital, in which a similar improvement had been noticed with fomentations in a patient whose opsonic index was as high as 2.

Mr. GERALD SICHEL (introduced) showed, on behalf of Sir Cooper Perry: (1) The boy, aged 8 years, who was shown at the February meeting as a case for diagnosis, and in whose case the chronic nodular annular patches had gradually increased in size; fresh, hard, painless, and but slightly tender, shotty nodules had also developed in the periosteum of the left temporal region. Dr. Galloway recognised the case as identical with one he had described in this journal as *Lichen annularis*. Dr. Pringle also had seen similar cases.

(2) A boy, aged 13 years, presenting symmetrical, painless *callosities*, covering in size an area of between a shilling and a two-shilling piece, on the back of each heel, and which he had noticed for the past eight or nine months.

THE DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.

A MEETING of this Society was held on Wednesday, February 22nd, 1905, Dr. H. WALDO in the chair.

The following cases were exhibited :

Dr. W. CLEMENT DANIEL exhibited a man, a photographer by occupation, with a *symmetrical eruption upon the legs* resembling a chronic eczema, the irritation of which was very severe at times.

The general consensus of opinion was that this was a case of Lichen planus.

Mr. T. J. P. HARTIGAN showed (1) a case of *tertiary syphilis* in a man, aged 90 years, with a history of ten years' duration. It was recorded by Mr. Waren Tay, to whom the exhibitor was indebted for the case, that "there is a very warty patch on the tip of the elbow, the papillæ and epidermis being enormously hypertrophied. Adjacent is a horse-shoe patch, suggesting tertiary syphilis. There are no other patches, and only doubtful evidence of slight scarring, and of its ser-piginous character. It is stated to have followed a blow which caused an abrasion, and that, working with his sleeves up, he often knocked the elbow." A histological examination showed a granulomatous infiltration of the corium very suggestive of syphilis, and there had been marked improvement under potassium iodide. The case was interesting as showing (a) that extreme old age was no bar to the occurrence of gummata, and (b) the enormous hypertrophy that may accompany the condition.

(2) A case of *atrophy of the nails following measles* in a girl aged 18 years. Three months after the exanthem all the nails were shed, and subsequently regenerated, except in the case of the thumbs, both index and middle fingers and the big toes, where they were either very thin, striated, and longitudinally fissured, or apparently absent, the posterior nail-fold having grown forward and become adherent to the nail-bed, through which more or less of the root of the nail could still be felt. No member of her family had any affection of the nails. There was no evidence of syphilis, and she had never had any other illness. The condition had persisted for thirteen years.

Dr. R. L. BOWLES remarked that anything which lowered the vitality of the system might produce various abnormalities of the nails, and he quoted the

observations of Sir Samuel Wilks who had seen atrophy of the nails after scarlet fever.

(3) A case of *ulcer of the cheek* in a man, aged 52 years, of four months' duration. It was roughly circular in shape, at least 1 cm. in diameter, and scabbed over. The glands were not enlarged, and there was no evidence of syphilis. If it should turn out to be a rodent ulcer, he thought it was unusually rapid in its growth. He proposed removing it entirely, and he would report on it histologically at a subsequent meeting.

(4) A case of *acute Lupus erythematosus* in a married woman, with a history of five months' duration. It began as two small patches on the cheek in front of the right ear and extended to the face, the pinna and concha of the ear, and the neck. Soon after, the fore-arms and backs of the hands and fingers became affected. The scalp was very scurfy, and at one time she was much exposed to the sun. There was scaling, but no vesication or evidence of atrophy. There was a good deal of pain and tenderness, and she was quite unfitted for work.

(5) A case of *congenital pigmented nævus* in a girl aged eleven years. There were numerous small, dusky, pigmented patches and spots scattered upon the left side of the neck, shoulder, and breast. There were also a few spots on the lobule of the corresponding ear. They were said to be getting darker, and some were becoming papillomatous. They were thickly grouped around the nipple, the areola of which was deeply pigmented. There was also a patch of dark hair behind the ear on the same side.

(6) A case of *acquired pigmented nævus* in a boy aged 11 years. Two years ago he noticed a freckle beneath the left eye which gradually became darker, and it was now black. Four more soon followed immediately below the first, and then another appeared on the lower lip on the right side. Other spots were to be found on the trunk and neck.

Among the suggestions for treatment put forward by the members of the Society excision of each nævoid spot was mentioned as being the most efficient method of radical cure.

(7) A case of *Lichen pigmentosus verrucosus* in a girl aged 12 years. The condition started five years ago on the forehead, and extended to

the neck, trunk, groins, and the front and inner aspects of the thighs. There were innumerable slightly pigmented, warty lesions, irregular in outline, and varying in size from that of a pin's head to that of a split pea. They were composed of a soft, friable substance that could be easily picked off with the finger-nail. He was not aware of ever having seen or heard of a similar case. A portion had been removed for histological examination, and he would endeavour to show a section before the Society on a future occasion.

This case excited considerable interest, but the majority of the members preferred to reserve their diagnosis until after the microscopic examination.

Mr. SPENCER HURLBUTT showed a *case for diagnosis*. The patient was a delicate-looking woman, aged 22 years, with a symmetrical eruption affecting both legs. The disease first appeared three months ago as a brownish-coloured spot on the outer side of the right calf, which was followed at intervals by similar ones on each leg, and these had gradually enlarged until the present time. There were now ten to twelve patches of varying sizes up to that of a florin situated upon the back and outer surface of the legs. The lesions consisted of fairly well-defined, non-indurated, circular, dull-red patches, with thin adherent scales, their general appearance being suggestive of psoriasis which had undergone treatment. The usual situations affected by that disease were, however, free from the eruption, and severe itching, especially toward night-time, was a prominent symptom.

The general opinion was that this was a case of seborrhoic dermatitis of a psoriasiform type.

Dr. GRAHAM LITTLE showed (1) a case of *Tinea cruris* in a private patient, a Japanese gentleman, an exponent of the art of ju-jitsu. The patient had noticed the eruption for about a month and a half, but could not be certain that he had not the first trace of it before he left Japan, six months ago. He was engaged in teaching the national form of wrestling, and in his exercises had to strip almost entirely, so that he might well have contracted the disease from a pupil. There were now large patches of scaly dermatitis occupying the perineum and groins with extensions on to the scrotum. On the left side of the cheek there was a circinate patch the size of a florin, having a somewhat intricate whorled pattern, suggesting tropical ring-worm. On the outer side of the ankle just below the external malleolus

there was a small patch the size of a sixpence, which was fading. No treatment had been applied to any of the lesions. There was no history of infection among his pupils, with the exception of one, a friend, who stated that he had some patches on his skin which he noticed while on the voyage from Japan. The patch on the groin was scraped, and in the scales thus obtained a very large-spored mycelium with unusually long branches was demonstrated.

(2) A case of *Pityriasis rosea* in a girl aged about 12 years, with very characteristic pale pink patches, in size about one quarter by half an inch, appearing first upon the upper part of the trunk above the clavicles, and arranged in lines directed obliquely from the summit of the shoulder to the clavicle. Upon the back in the intervertebral groove there were numerous similar patches and also smaller papules, round and faintly scaly. The eruption had made its appearance two days previously, and it was not now present upon the limbs or lower upon the body than the groin. It itched slightly. There was no similar eruption in any member of the family. This was the second case the exhibitor had seen of the disease this week, and it was probably true that the malady was an exanthem occurring in epidemic form during certain periods of the year.

Dr. WILFRID WARDE agreed as to the epidemic character of the disease, and he remarked upon the general good health of the patients. He thought that the so-called "herald-patch" was frequently missed, both by the patient and the physician.

(3) A case of *Lupus vulgaris* of the nose and cheek in a little weakly East-end child who had had a remarkably complete series of tubercular affections, commencing with a tubercular ulcer upon the right conjunctiva and cornea for which the eye had been enucleated eight years ago. Six years afterwards she developed lupus of the nose, which had run a very acute course and had speedily ulcerated, producing considerable loss of tissue in the cartilaginous portion of the nose. She was treated at first with cod-liver oil and thyroid extract for some months, and later with X-rays, which had been continued for many months with apparently no good effect. After several months of this treatment sudden improvement took place up to a certain stage, but there it stopped, the nose being still the seat of active disease. The application of Finsen light by the Finsen-Reyn lamp was then tried, and, in all, sixty exposures had been given of an hour and a

quarter at a sitting, at daily intervals. The result had been satisfactory beyond belief to those who had seen the case at its worst. It was also an interesting fact that this patient had been the subject of an acute attack of typical *Lichen scrofulosorum* of the trunk, and she had been shown with this eruption at the Dermatological Society of London, in the *Transactions* of which it was fully recorded.*

All the members agreed upon the excellent results which had been obtained in the treatment of this case.

(4) A case of *Linear lichen planus* in a middle-aged woman, who had been under observation since August of last year. At that time she presented herself with no symptoms of the disease except a broad, linear patch running vertically across the popliteal space on the left side. This patch was of a violaceous tint, and the skin was thickened along its course and was intensely irritable. But there were no papules distinctive of *Lichen planus* on any part of the body, until about a month ago, when she began to develop an acute attack of the disease. It was interesting to observe that new papules continued the line of the original streak from the popliteal space up the back of the right thigh as far as the buttock in an almost unbroken line, other papules being distributed extensively upon the body, but without any linear arrangement. She had well-marked lesions of *Lichen planus* upon the buccal mucous membrane, which had also developed within the last few weeks. The itching was a very severe symptom, and it kept the patient awake at night.

(5) A case of *syphilis* in a man, aged 25 years, with an affection of the upper lip which it was a little difficult to classify, the question being whether it was a primary or a tertiary ulcer. The whole of the lip was greatly swollen, and at each angle of the mouth there was a deeply-excavated ulceration scabbed over, the intervening portion of the lip being occupied by a papillomatous infiltration resembling the appearance of frambœsiform syphilis. The man absolutely denied previous lesions of any kind; there was no scar upon the penis or upon any portion of the body, and no history of a secondary rash at any time. But the uvula had been apparently destroyed by ulceration and was now merely rudimentary, and there was a deep ulcer upon the back of the pharynx very suggestive of tertiary disease. The

* *British Journal of Dermatology*, 1903, p. 210.

absence of primary and secondary symptoms was peculiar. It should be mentioned that there was no pronounced enlargement of the glands in connection with the deep ulcers of the lip, which, it might be considered, precluded the diagnosis of primary sores here.

MR. ARTHUR SHILLITOE suggested the possibility of the case being an instance of tertiary symptoms in a patient the subject of congenital syphilis, but the teeth and physiognomy generally did not confirm this possibility. The general opinion supported the diagnosis of tertiary syphilis.

MR. GEORGE PERNET showed a case of *superficial scarring and telangiectases of the left side of the face and neck following an X-ray burn*. The patient, aged 28 years, was treated three years ago in the provinces for what was said to be a tuberculous lesion upon the left side of the chin. As far as she recollected, the affected part was exposed on eight occasions to the X-rays for about ten minutes at a time, the eyes only being protected, but not the adjacent parts of the face and neck. The patient stated that as a result the face was dressed and bandaged for three months. The parts now exhibited the well-known characteristic features following such burns. The original lesion for which she had been treated appeared to be healed.

DR. V. H. RUTHERFORD showed microscopic sections from the case of *multiple sarcoma cutis* which he had exhibited at the previous meeting of the Society :

(1) An early nodule—the size of a pea—over which the skin still retained its natural colour, displayed chiefly fibrillary bundles with a small number of cells in various stages of development, some being round, others elongated with fine protoplasmic processes, and others again with irregular outlines.

(2) In a later nodule—the size of a bean—over which the skin had become red, the bundles of fibres were replaced by typical small round cells (lympho-sarcoma). The sections were stained with hæmatoxylin.

A post-mortem examination was made on Monday, February 20th, when a considerable growth was found in the mediastinum (probably primary), pressing upon the right bronchus, and smaller growths sparsely distributed in the pleura, lungs, retroperitoneal glands, etc.

CURRENT LITERATURE.

ON THE QUESTION OF BLASTOMYCOSIS OF THE SKIN AND ITS RELATION TO "FOLLICULITIS EXULCERANS SERPIGINOSA NASI" (KAPOSI.) BRANDWEINER. (*Archiv f. Derm. u. Syph.*, August, 1904, p. 49. One plate.)

THIS paper is based on a case which occurred in Dr. Matzenauer's clinique in Vienna. The patient was a shoemaker, aged 37 years, who suffered from a papillated crusted lesion on the lower part of the left side of the nose. The diseased patch occupied the ala nasi, and extended up as far as the bridge, where it faded into the surrounding skin. It was reddish-brown in colour, raised and irregular in shape, and covered with yellowish inspissated pus. It had been noticed first about a year before. On histological examination the stratum corneum was found to contain numerous unicellular organisms of from 4 to 10 μ in diameter, which stained with polychrome methylene blue, were doubly contoured and were believed to be blastomycetes. The epithelium had proliferated and presented small necrotic pustules containing these organisms. There was a round-celled infiltration in the corium in which the blastomycetes was also detected. An attempt to cultivate the organisms and to inoculate them in lower animals was unsuccessful. On the ground of this not quite convincing case the writer took the opportunity of reviewing the literature on the subject. He referred in detail to several cases described by Kaposi with the title of "Folliculitis exulcerans serpiginosa nasi," which he regarded as most probably identical with "blastomycosis."

J. M. H. M.

A NOTE ON THE TREATMENT OF SYPHILIS. JONATHAN HUTCHINSON. (*The Practit.*, August, 1904, p. 145.)

IN this short communication the writer refers at the outset to the remarkable fact that mercury obtained its reputation in the treatment of syphilis almost immediately after the introduction of that disease into Europe, and "the pills—which were known as Barbarossa's, and of which a large quantity was furnished for the treatment of Francis the First—were probably essentially the same as those which Messrs. Burroughs Wellcome and Co. now supply by the million." In opposition to a number of writers, especially on the Continent, the writer is a strong advocate of the early use of mercury, and of what has been called the "suppression treatment." He commences mercurial treatment immediately the syphilitic character of the sore is definite. The prevention of late or tertiary phenomena being the most important aim in the treatment of the disease, efforts should be made to this end, and he considers that the immediate use of mercury, which may prevent the secondary stage from developing, has also the effect of reducing the possibilities of the development of the late stage. With regard to the length of time the patient should continue to take the mercury the writer strongly believes in the efficacy of prolonged and continuous treatment. He does not see the object of intermitting the course and giving the specific virus any chance of renewing its activity unless the mercury is interfering with the health of the patient. The plan of treatment usually adopted by the writer is as follows: "A pill is prescribed containing one grain of grey powder and one of Dover's

powder, and this the patient is to take after meals, and only three times a day at first. If no diarrhoea follows, the pill is to be given four, five, or six times a day." The diet is regulated, and the patient is told that the treatment must be continued without intermission for a year at least. An alum mouth-wash is ordered to prevent pyalism. If there is debility, a grain of quinine is added to the pill. In using the iodides he considers that the iodides of mercury are much less manageable than the two separated, and prefers to give the iodide of potassium in a fluid dose along with the mercurial pills.

J. M. H. M.

URANIUM IN THE TREATMENT OF LUPUS: A PRELIMINARY NOTE. NORMAN WALKER. (*The Scot. Med. and Surg. Journ.*, September, 1904, p. 207.)

THE method of applying the uranium which was adopted by the writer was to prepare an oxide of uranium from the nitrate, incorporate it with a negative base such as bees-wax, and spread this on leather to form a plaster of the usual thickness and the required extent. The plaster is enclosed in waxed paper gummed at the edges. The uranium plaster was applied at first in cases where the limbs were affected with lupus and later on the face. Exposure for three days and three nights to an affected arm was followed by no reaction, but on the face it was found that a slight reaction followed in cases where the exposure exceeded twenty-four hours. The plaster may be worn only at nights and removed in the morning. The results have been encouraging, and the risks appear to be negligible. The treatment is cheap, since the cost of making the plaster has been estimated at about one shilling, and experiments have shown that the plaster remains active after four months. This short paper is illustrated by reproductions of four skiagraphs, one taken by thorium and the other three by uranium plasters. These demonstrate the fact that the radio-activity of the uranium salt is much greater than that of thorium.

J. M. H. M.

OBSERVATIONS ON THE USE OF EUCAINE B. AND ADRENALIN AS A MEANS OF INDUCING LOCAL ANÆSTHESIA. GEORGE L. CHIENE. (*The Scot. Med. and Surg. Journ.*, September, 1904, p. 215.)

IN this communication the writer makes some interesting and instructive observations on the value of combining adrenalin with encaine or cocaine as a local anæsthetic for minor operations. Satisfactory results were obtained by employing a mixture of a 2 per cent. solution of eucaine B. and 1-5000 adrenalin chloride, thirty minims of the solution being injected. The chief drawback to the method was the fact that adrenalin solutions did not keep well, and readily became inert and contaminated. This difficulty has now been obviated to a large extent by the introduction by Messrs. Burroughs Wellcome and Co. of a new preparation of the supra-renal gland called "Soloid Hemisine," which is said to represent the hæmostatic principle of the supra-renal gland in a more stable form. The writer has had compound soloids prepared by the same firm which when dissolved in 10 c.c. give a solution of 1 per cent. eucaine B. and 5 m. of adrenalin (1-1000.) By injecting this a carbuncle the size of the palm of the hand was excised without pain or discomfort, and at a later date the surface was skin-grafted, the same

anæsthetic being used. The writer believes that the addition of the adrenalin not only increases the efficiency but also the safety of the eucaine or cocaine as local anæsthetics.

J. M. H. M.

DERMATITIS FRAMBÆSIFORMIS. F. SAUERBERGER (*Archiv f. Derm. u. Syph.*, October, 1904, lxxii, p. 3).

IN this contribution the writer describes an unusual case which occurred in Professor Janovsky's clinic at Prague. The patient was a coal-miner, aged 18 years. At the age of 14 he began work in a mine and soon afterwards he suffered from a severe attack of furunculosis, which persisted for a year. As it got steadily worse he had to leave his work for a time. When he was able to work again he got employment in another mine. After some time he went to the original mine and the furunculosis returned rapidly and he was again compelled to leave work. He blamed bad drinking-water as the cause of it. Several other miners in the same pit were similarly affected and among them was the patient's father. Soon after leaving work for the second time the pustular lesions began to be replaced by raised papillomatous masses which were especially well-marked about the face and neck. The eyelids, forehead, tip of the nose, nasal orifice, lips, chin, and left side of the cheek became covered with crusted papillomatous lesions. A few similar lesions developed on the body in the inguinal regions, and both the cervical and inguinal glands were enlarged. A microscopical examination of one of the lesions showed a proliferation of the interpapillary processes, and a dense cellular infiltration in the papillary and sub-papillary layers, consisting chiefly of leucocytes and mast-cells and dilatation of the capillaries. The lesions did not react well to local treatment, but eventually with tonics and by persevering with local remedies a cure resulted. There was no history or evidence of syphilis. The disease was similar in many respects to tropical frambæsia or yaws, and corresponded closely to a case which Lewin described as sporadic frambæsia.

J. M. H. M.

ON THE RADIO-THERAPEUTICS OF RINGWORM. SABOURAUD.
(*Ann. de Derm. et de Syph.*, July, 1904, p. 577.)

IN a previous paper (published in January, 1904, in the *Annales de l'Institut Pasteur*) Sabouraud had proposed a method of treating ringworm with X-rays, which he sums up as follows: "The application in one sitting upon a given point of the scalp of a quantity of X-rays equal to $4\frac{1}{2}$ -5 H-units of Holzknicht is made; fifteen days later a complete epilation will occur on the region treated, healthy as well as diseased hairs being shed. New and healthy hair will commence to grow ten weeks after the treatment, and will be completely restored within ten weeks. The infectivity of the disease will cease with the fall of the last diseased hair, within twenty-five days at latest of the treatment." This formula, Sabouraud maintains, has been amply proved to be true by his experience of the six months which have intervened since his paper of January, 1904. Some very striking results are quoted. Thus while in six months before this treatment was adopted 57 patients were discharged as cured, in the past six months 134 such patients were discharged; moreover, a very large number of patients were treated without admission and also cured. An entire section of the hospital,

consisting of one hundred beds set apart for favus cases, has been closed and will be converted to the uses of general medicine, as being no longer required for its former purpose.

Certain additional knowledge has been afforded by the experience of the past six months, which may be stated in the following practical rules: The penetration of X-rays is proportional to their number; the more penetrating they are, the more numerous they are. The danger of X-rays is proportional to their penetration; it is thus more dangerous to handle X-rays of 8° – 11° (on Benoist's radio-chromometer) than rays of 3° – 5° . Now tubes change progressively with use and these changes are marked by colour changes in the glass. At first, after about ten hours' use, the tubes take a violet coloration; with this there is no impairment of function. But with further use, after about thirty hours, a brown tint becomes marked, and the tube is said to be "smoked." With this change it becomes increasingly difficult to obtain rays of a low degree of penetration. For epilation rays of all degrees of penetration serve equally well; rays of 3° are as effective as rays of 11° , but the treatment must be for a longer time. Thus a tube working at 3° caused an epilation in twenty-five minutes. The same epilation would result in eleven minutes from a tube at 8° – 11° ; and if one used the latter tube for twenty-five minutes, a dermatitis would result. This is entirely unnecessary for epilation and is attended by mischievous consequences, even when quite slight, and must be avoided. All forms of dermatitis, except that of transient erythema, produce permanent baldness. Permanent alopecia may also result without dermatitis in cases where the amount of X-rays given has been insufficient to cause epilation, and a second *séance* has been necessary. In this case certain hairs will have received a dose beyond the maximum for safety, and these will be permanently destroyed. For safe working, it is necessary to have a measure of the rays coming from the tube at any given time; and the measure must be constant for every variety of tube. This is obtained by certain colour changes taking place in specially prepared substances, these changes being proportional to the amount of X-rays derived from the tube. The pastilles of Holz knecht have been used for this purpose, but they are a secret preparation, expensive, and not everywhere procurable. Sabouraud has devised small discs made of paper which is the same as that used for screens and is coated with a preparation of platino-cyanide of barium. These discs change in colour in a fixed manner, comparable from time to time with test-colours, and their use makes it impossible, with care, to overstep the limits of safety.

E. G. L.

SYPHILIS AND CANCER. ETCHEVERRY. (*Ann. de Derm. et de Syph.*, August–September, 1904, p. 797.)

THIS research was undertaken in Audry's Clinique at Toulouse, and the consideration of the connection between these two diseases was directed to the occurrence of lesions on the tongue and buccal mucous membrane. These facts are grouped in three classes, according as: (1) cancer supervened, in syphilitic patients, upon a preceding leucoplakia; (2) without leucoplakia, but in the presence of other local syphilitic lesions, such as gummata, scars of gummata, or of hard chancres; and (3) in the absence of all local signs of syphilis. Thirteen cases of epithelioma developing upon syphilitic leucoplakia are detailed under the

first heading. This sequel is relatively frequent. In the second group twenty-two cases are noted. In the third group no direct transformation of syphilitic into epitheliomatous lesions could be established, but the fact of previous syphilis was ascertained in all the fifteen cases quoted. Etcheverry, struck with the singular frequency of association of the two diseases, speculates whether there may not be some direct predisposition in syphilitic patients, as such, to develop cancer. In epithelioma of relatively young patients he states that syphilis may almost always be found as a previous accident. The greater frequency of cancer of the mouth in men than in women coincides with the greater frequency of syphilis in men; according to Fournier, syphilis is eight times more common in males. Etcheverry hazards the suggestion that the cachexia produced by syphilis may be a directly provocative cause of ensuing cancer. As regards the treatment of these mixed cases of syphilis and cancer, the administration of mercury, preferably by injections of calomel, influences favourably the syphilitic element of the disease, and occasionally, as a temporary effort, the epitheliomatous development is checked by this drug. On the other hand, iodides are distinctly mischievous to the malignant growth, and should not be given.

It is probable that the same close connections obtain between cancer and syphilis of the rectum as has been here noted in the case of the mouth, but observations on this point are too few to be of value.

A very full bibliography is added to this careful paper.

E. G. L.

ON ADENOMA SEBACEUM. BUSCHKE. (*Derm. Zeitschr.*, Bd. xi., Heft 7, p. 467.)

THE patient was a boy, aged 13 years, in whom the eruption of small tumours had occurred at the age of five, coming out suddenly after an attack of measles. The distribution and appearance of the single lesions on the face was of the characteristic type of reddish-brown nodules situated on the nose and contiguous portions of the cheeks. He had also numerous fibromata on the back, and a widespread eruption of small, pale yellow, seed-like tumours all over the back, the little tumours resembling milium, and on close examination appearing to be pierced by lanugo hairs. A histological examination of all classes of tumour showed them to be either pure fibromata or angio-fibromata, though Buschke admits that in the case of the face tumours the excision was so superficial that it is possible that deep sebaceous glands might be present below the point at which the excision took place. The boy was clever at work, and generally showed no physical or mental defect other than the presence of the cutaneous anomaly.

A. W.

ON THE PATHOGENESIS OF COLLIQUATIVE BULLÆ. KREIBICH. (*Derm. Zeitschr.*, Bd. xi., Heft 5, p. 315.)

AFTER reviewing shortly the theories at present put forward for the production of colliquative bullæ, Kreibich enters into great detail in the description of his experiments. He finds evidence that in *Zoster hystericus* there is an acute œdema consisting of fibrinous exudation which enters into the cells and causes their necrosis without separating them from their deep attachments. By irritating the same part three times running with the poison of *urtica urens*

Kreibich was able to produce a colliquative vesicle, since the œdematous process then reached to the papillary body. Similar is the pathogenesis of true herpes zoster and in all probability of hydroa vacciniforme. To sum up the results of the investigation he states that "Colliquative bullæ are found in processes which are allied to urticaria but differ from this in the greater duration of the vascular lesion and by its situation in the papillary body. The colliquation of the epithelium is produced by the action of an exudation rich in fibrin on the epithelial cells, which have suffered in their nutrition but which have maintained their connection with the cutis. The disturbance of nutrition is a combined result of the vascular lesion, the pressure of the exudation, and the resultant anemia."

A. W.

FORMALIN AND ITS ACTION ON FAVUS MOULD. BOGROW AND SCHARKEWITSCH-SCHARSCHINSK. (*Derm. Zeitschr.*, Bd. xi, Heft 5, p. 329.)

THIS is the record of careful investigations of the action of formalin on the achorion, both culturally and on the diseased scalp. The results show the absolute futility of using formalin in a watery solution, but the authors think that further work on the action of spirituous solutions and vapour is desirable.

A. W.

ON A CASE OF ERYTHEMA NODOSUM OF UNUSUAL COURSE AND ATYPICAL LOCALISATION. EINIS. (*Derm. Zeitschr.*, Bd. xi, Heft 7, p. 493.)

A LITTLE boy, aged 2½ years, was brought up with four slightly raised swellings, two, each as large as a half-crown, being situated symmetrically on the cheeks, and two, each as large as a sixpence, on the temples.

The history showed that exactly a year before the child had suffered from a similar eruption on the lower legs, and the doctor who treated the child for former attacks identified the eruption with the fresh one. The peculiarity in the course showed itself in the access of colour and pain in the nodes every day about noon, though there was no fever, and the child seemed to be in very good health with the exception of a few swollen sub-maxillary glands.

A. W.

SEVERAL CASES OF ATROPHY OF THE SKIN. ALEXANDER. (*Derm. Zeitschr.*, Bd. xi, Heft 5, p. 338.)

FOUR cases in all are alluded to in this paper. The first patient, a man aged 31 years, showed all the symptoms of an epidermolysis bullosa, with slight ulceration, but the affection was said to have begun at the age of 18 and only to occur periodically. The second case was that of an old woman, aged 70 years, who also had an abdominal tumour, of which she died. Material showed that there was a complete loss of the papillæ, the elastic tissue had disappeared to only the slightest traces, and there were signs of inflammatory infiltration present. The third case was that of a woman, aged 55 years, with marked syringo-myelia; and the rash, which appeared as small nodules, terminating in atrophy, affected the axillæ, the inner sides of the upper arms, the groins, the inner sides of both thighs, the back, and abdomen. The author says that one is tempted to connect this

with the condition of the cord, but to do so is the purest theoretical speculation. The fourth case was a woman, aged 42 years, who showed on the left side of the nose a circular patch as large as a sixpence, over which the skin was of a bluish-red colour, and somewhat infiltrated. There were some scars caused by the therapeutic use of electrolysis.

(From the short description of this last case it does not seem clear why the diagnosis of Lupus erythematosus was not made.—A. W.)

A. W.

ON THE TREATMENT OF TYLOSIS PALMARIS IN ADULTS.

MAYER. (*Derm. Zeitschr.*, Bd. xi, Heft 5, p. 865.)

MAYER recommends the rubbing in of rheumasan, a salve-soap containing 10 per cent. of free salicylic acid. This should be massaged in for at least five minutes and then glacé gloves should be worn at night. The patient should be cautioned to discontinue the use of the drug for a few days on the first appearance of redness.

A. W.

PSORIASIS VULGARIS OF THE SKIN AND MUCOUS MEMBRANE, ITS PATHOLOGICAL POSITION AND ÆTIOLOGY.

P. THIMM. (*Monatsh. f. prakt. Derm.*, July 1st, 1904, p. 1.)

DR. THIMM gives the history of a patient, a man aged 36 years, who had been under his care for five years. He had an obstinate recurring extensive psoriasis eruption of the skin of the trunk and limbs, typical psoriasis lesions of the upper and lower lips, extending on to the mucous membranes of the mouth and nasal cavities. In addition, the mucous membrane of the mouth showed, while he was under observation, various circumscribed diseased patches, setting in synchronously with the eruption on the skin, which also disappeared at the same time after general treatment with arsenic. Schimmer's typical leucoplakia was also present, the patient being an immoderate smoker, and this continued in spite of all treatment. There were no signs of syphilis.

Microscopical examination of two mucous membrane lesions showed great œdema, enlarged intercellular spaces, thickening of the epidermal covering *in toto*, but a thinning of the rete over the elongated, high-reaching papillæ. Small-celled infiltration of the upper layers of the corium, extending even up into the epithelium, was also present.

But what was not visible, nor present in any of the sections, was the parakeratotic heaping up of scales of the psoriasis lesions. Exceptionally this may be wanting in cutaneous psoriasis patches, but its absence is, as a rule, or even always, characteristic in psoriasis of mucous membranes. In certain sections, however, the uppermost epithelial layers, one found, to a depth of three cell layers, were pressed together to form a dark-coloured narrow band, but having regard to the smooth contour of the surface this could hardly be looked upon as a partly developed scale. The pathological characters of any lesions are to a certain extent altered according to the position in which they occur. By the word "parakeratosis" is understood, apart from the heaping up of dry, scaly formations, a condition in which we find the following changes of the epithelium: parenchymatous œdema, extension of the basal horny layer, abnormally scanty fat

contents of the same, want of keratohyalin, and abnormally good preservation of the nuclei. Such are, however, pathological changes of the external epithelium, but normal conditions of the mucous membranes. Parakeratotic changes of the mucous membranes of the mouth cannot be considered diagnostic of psoriasis. But the changes in the papillæ, the infiltration of the upper layer of the corium, the widening of the blood-vessels, the dilatation of the lymph-channels, taken in conjunction with the clinical symptoms and the results of treatment, leave no doubt that the case was one of true psoriasis vulgaris of the mucous membrane of the mouth. Previously, very few cases of scaly lesions of the mucous membranes had been described, and in psoriasis of the skin the extensive and destructive infiltration seen in these lesions of mucous membranes is unknown.

The aetiology of psoriasis, whether of the skin or mucous membrane, has been, and is still so hotly discussed, that the translator can but mention the author's conclusion that the pathological picture of his case points anatomically to an inflammatory origin, and aetiologicaly to a parasitic origin of psoriasis.

J. L. B.

ERYSIPELAS NEONATORUM GANGRÆNOSUM. E. NOHL. (*Munch. med. Wochenschr.*, September 13th, 1904, p. 1648.)

THE child was born on February 29th, and was apparently healthy at birth: she developed diarrhoea on the fourth day, and redness and swelling of the genital region on the sixth.

Seen for the first time on March 7th, the labia majora were much swollen, red and shining and painful. Both thighs presented a firm œdema and looked blue and marbled. There were frequent motions like pea-soup. On March 9th the temperature rose above normal for the first time and, with the exception of the first two evenings, when it sank below normal, it remained elevated till the child died, reaching 40° C. on March 11th, and 40·5° C. on March 15th.

On March 12th a large ulcer appeared on each labium following a bullous upheaval and casting off of the epidermis, and at the same time the skin over the trochanteric region on each side commenced to necrose. The œdema had involved the whole of the lower extremities, the affected parts being pale and flecked with blue; small bladders filled with yellow serum appeared on the dorsal surface of each foot.

Fresh areas of necrosis developed. The ulcers on the labia turned black. On March 15th the child died, with symptoms of meningitis. A post-mortem examination was not allowed.

The author discusses the differential diagnosis between erysipelas and œdema neonatorum. He quotes a passage from Strümpell, as well as a case of his own, to show that fever sometimes appears after the eruption in erysipelas. He further records the fact that there had been a great deal of infectious illness in the house before the birth of this child—severe measles, whooping-cough complicated by empyema, ulcerated throats with otitis media—whilst the mother developed parametritis on the second day.

W. B. W.

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AN INQUIRY INTO THE ÆTIOLOGY OF INFANTILE ECZEMA.*

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SECTION I.—GENERAL SCHEME OF THE INQUIRY.

INTRODUCTION.

THE subject of eczema, although so much has been written about it, is one which still gives rise to the most varied and contradictory opinions. This is true, whether we consider its definition, ætiology, pathology, or treatment. This inquiry was undertaken in order to ascertain which of these divergent views might be confirmed or negatived by a carefully recorded series of cases. To attempt to include all varieties of eczema in such an inquiry promised little result. I thought it best, therefore, to limit myself to some form of the disease which would be universally accepted as typical, and of which it would, easily, be possible to obtain a series of comparable cases for investigation. It seemed to me that the variety known as infantile eczema complied with these two requirements. It presents further the advantages that, being usually of fairly recent occurrence, when first seen, the details as to its beginnings have not been forgotten; that information of all kinds can be readily obtained from the watchful mother or nurse; that the quantity and quality of the infant's "ingesta" and "excreta" can be easily ascertained; and, lastly, that there is, in such cases, no item of mental worry, overwork, etc., to

* Being a Thesis for the degree of Doctor of Medicine in the University of Cambridge.

complicate the aetiological problem. I hoped that the evidence obtained from a careful inquiry into this single small variety of eczema might be of use in studying the affection at other periods of life.

The sixty cases which I have collected for this thesis have come under my care between the years 1897 and 1903, and are in no way selected. For this inquiry I have limited the term "infantile eczema" to cases beginning in the first year of life. I have attempted in each case to obtain full and accurate information concerning the life and surroundings of the infant prior to the first appearance of the disease. This has been supplemented by a careful physical examination of the infant and its mother, and a full inquiry into its family history. I hoped, at the outset, to add to this a physical examination of the father in each case, but I found this was practically out of the question in hospital patients.

The following printed form of questions has been used throughout this inquiry.

Date of admission
 Date of birth
 Date of vaccination
 Name Age
 Address
 Age of mother Age of father Age of brothers
 Age of sisters
 What is colour of mother's hair? Has mother ever had any skin disease?
 Has mother had a scurfy head? Examine carefully.
 Has father had any skin disease? Has father had a scurfy head?
 Examine if possible.
 Has anybody besides the mother nursed the child regularly?
 If so, examine carefully.
 Have any other children had any skin disease?
 Or got *Pediculi capitis*?
 Has it slept in the same bed as mother? How long?
 On her right side or her left?
 When did the rash first appear? On what part?
 Where did it spread to next?
 Has it ever got quite well since it first appeared?
 Did the child go out of doors before the rash appeared?
 What soap was used to wash the child?
 Has child been fed on breast? Since birth till when?
 Were both breasts used equally?
 Was any other food given besides the breast milk? What?

What is the child having now?

- { 1 In morning.
2 In afternoon.
3 In evening.

Does it take well? Is it losing flesh?

At what age did it cut its first tooth? How many teeth has it now?

Does it vomit? Is there or has there been diarrhœa?

Can it walk? Since when? Can it talk? Since when?

Is there any peculiarity in shape of head? Are the ribs beaded?

Is spleen palpable? Is the belly prominent?

Are any joints enlarged? Does the head sweat at nights?

Does it kick off the bedclothes? Does it sleep well?

Character of eruption?

Some of the questions have proved of little value.

Thus, the question, "Did the child go out of doors before the rash appeared?" has little point in the case of hospital patients in whose houses the kitchen door opens into the street, for the child is, often, practically out of doors, when it is in the house. The question as to what soap was used, produced such an endless variety of answers, that nothing definite could be made of it. But the two questions have, now and again, elicited information of some value. Thus, in one case, the mother told me that the eruption suddenly came out violently, after washing the head with coal-tar soap, to get some scales off; and in another case, the mother said the rash appeared when the child was taken for the day to Cleethorpes.

I regret that the question as to vaccination was not systematically asked, until about half the cases had been recorded. My reason for not doing so at first was, that it seemed almost wrong, even to suggest such a possibility to the parent; but, from the experience I have obtained since I began to make systematic inquiry, I am more firmly convinced than before, that vaccination stands in no ætiological relation to infantile eczema.

Another question, from which I hoped much and got little, is that which relates to the side of the mother, on which the child slept in bed. I thought, that, possibly, the common site of the first outbreak on one or other cheek, might be determined by contact with the mother's sweating chest, possibly wet with milk. Whether this plays any part or not, the answers to my questions give no clue, for in the cases, some eleven in number, where the rash appeared first on the left cheek, about one third lay usually on her right side, one third on

her left side, and the remainder on both sides equally. And so on with cases beginning on the right cheek, etc.

The presence of *Pediculi capitis* in the mother's head is also, I think, of little value. These are so common in the heads of females, both young and middle-aged, amongst the poor of Sheffield, and are, for the most part, so harmless, that their presence is probably of no importance as a source of irritation to the child's skin. At any rate, the evidence I obtained is not sufficient to warrant any positive statement.

The details of these sixty cases are given in the accompanying tables. They are analysed in Section III, and are also, where possible, illustrated by diagrams and charts. Section II gives an epitome of the general views as to the ætiology of infantile eczema. Section IV contains the conclusions which I have formed from a study of these cases.

SECTION II.—THE VIEWS OF VARIOUS SCHOOLS OF DERMATOLOGY, DURING THE LAST CENTURY, ON THE SUBJECT OF INFANTILE ECZEMA.

IN this section I have collected a few short extracts from the works of various authorities, who have written on diseases of the skin during the past and the present century. Though not intended to be complete, they are fairly representative of the various schools at different periods. They are arranged in the order of date of publication.

Alibert, in his *Text-book and Atlas* (1806), gives an illustration of a case, in which the hairy scalp is chiefly affected, together with the forehead and a few scattered spots on the forehead and nose.

His definition is as follows :

“A *tinea* showing yellow crusts, easily detached from the hairy scalp, or secreting a mucous material which mats the hair together. It not only attacks the hairy scalp, but also spreads sometimes to the forehead, face, temples, and ears.”

He distinguishes between this and “*croûte de lait*,” which term he keeps for the seborrhoic scales on the head of an infant at the breast.

These, he says, are natural and not a disease. He describes *Tinea muciflua* as occurring during the first two years of life, frequently associated with improper lactation, or dentition, or in children of scrofulous or lymphatic parents.

He also describes four cases, of which one beginning at three and a half months is a typical infantile eczema, whilst two of the others, at twelve months and two years respectively, appear to be rather *Impetigo contagiosa*.

Willan and Bateman (7th edition, 1829) give a long account of it, of which the following points may be quoted :

Porrigo larvalis, or "mask-like porrigo," with the following synonyms—Milk scall, *Achor*, *Crusta lactea*, *Tinea lactea*, *Scabies capitis simplex* (Plenck), *Tinea muciflua*, *Die Kopfrinde*, *Der Milchgrind*, *Croûte de lait*.

"It is a disease of infancy, generally non-contagious. It appears first on the forehead and cheeks. There are numerous pustules on a red base, which burst and form scabs, yellow or green, until a mask is formed. The odour is rank and peculiar. It runs a variable course. The discharge may be slight or profuse. There are smaller patches on the neck and breast, also on the limbs. The ears and scalp are usually affected. The child's health remains good except for loss of sleep. The parotid and mesenteric glands may be enlarged. Marasmus with diarrhœa and hectic may kill the patient. It usually ends favourably, but the diarrhœa is long and uncertain. It may recur. It is due to undigested food."

He also quotes Dr. Underwood as saying :

"I never saw an infant much loaded with it, but it has always been healthy, and cut its teeth remarkably well. In general, however, although it appears in the most healthy children, yet it is the consequence of repletion and the irritation of undigested food upon highly excitable systems; and in these it probably prevents the attack of more formidable diseases."

Hebra, *Diseases of the Skin*, 1868, defines eczema as follows :

"A disease of the skin, of usually chronic course, characterised either by the formation of aggregated papules and vesicles, or by more or less deeply red patches covered with thin scales, or in other cases by a moist surface, while in any of these forms there may be developed in addition partly yellow and gummy, partly green or brown crusts. This affection is constantly accompanied by violent itching, which leads to excoriations, and it is not contagious."

He gives no special account of the form seen in infants, as all through his work he seems anxious to group together, rather than to split up, the eczemas. He does, however, refer to this condition in various places, thus :

"It may affect the whole of the face or only certain parts of it, and I may here remark that we usually observe this form of eczema occupying both sides of the

face in equal extent and intensity. That there are exceptions to this rule is not to be wondered at, and they are the more explicable when we remember that the exciting causes of eczema often affect only one side of the face."

Again :

"Crusta lactea runs in most cases, if not an acute no very chronic course, and is mostly over in the space of a few weeks."

Under *Ætiology* I quote the following points :

"Rachitis also frequently appears in company with eczema without, however, our being able to assign this diathesis as the cause of every case of the cutaneous affection at this age."

"As great abuse is made of the teething of children, as of their temperaments, and just as every cough, every colic, fever, diarrhœa, cramp, or fit in an infant is put down to teething, so eczema is ascribed to the same cause when it appears at the same period. Now, although I by no means ignore the influence which this physiological process is capable of exerting upon the whole of the organs and functions of an infant, yet I cannot admit it to be a cause of eczema ; because any conscientious and accurate observer may convince himself, that this malady occurs just as much before, as during the period of dentition, and offers the same symptoms, the same intensity, and the same extent, without being the least affected by the completion or the delay of the eruption of the teeth."

Again :

"A favourite explanation of the occurrence of cutaneous diseases in general, and of eczema in particular, has been that of hereditary transmission. I cannot coincide with this view, for I have seen many women who, either while unmarried, or as mothers, have repeatedly suffered from eczema, sometimes during their pregnancies, and yet their children have never been attacked by it. I can even adduce the case of those who have been eczematous for years and have given birth during that time to seven, eight, nine, or ten children, all entirely free from this malady. The fact that in a few cases whole families may be found affected with it must be viewed as exceptional, when contrasted with the general results of experience, and can, at the utmost, only prove that eczema in parents does not exclude its occurrence in their children."

And again :

"Lastly, the symmetrical character of an eczematous eruption is more simply accounted for by an original participation of the nerves than by the supposed excretion of impurity in the blood. It is no very bold assumption to suppose that in eczema also it is faulty innervation which is the most important element in its production."

Erasmus Wilson, in his various writings, gave particular attention to the subject of infantile eczema (London : Churchill, 1870). He gives an account of an investigation which he made into the causes

and varieties of the condition. The investigation, as published, is lacking in many details, and seems to have been made with a somewhat preconceived bias towards dietetic causes, which somewhat impairs its value; but on many points he has some interesting observations.

He takes thirty-four cases which came to him in one year, and analyses them in many ways.

Sex.—Of thirty-four cases, twenty-two were male and twelve female.

Age at first appearance.—Twenty-one occurred during the first three months of life, seven between the third and sixth month, and six at a later date.

Season.—Of thirty-four cases, eleven began in December, four in January; that is, nearly half the number began in these two months, whilst, he says, twenty began in the colder months and fourteen in the warmer.

Vaccination.—His statements under this heading are vague and of no definite value.

Food.—Thirty of the cases were breast-fed, only four hand-fed.

Other children affected.—In four cases only had one other of the children in the family been affected.

In one case, four children out of nine had suffered.

As conclusions from his own observations Wilson gives the following five causes as prominent in their influence:

1. Food; insufficient or improper.
2. Temperature.
3. Diathesis.
4. Dentition.
5. Vaccination.

He further says (*Lectures on Ekzema*, 1870, p. 247):

“Ekzema infantile, like Ekzema adultorum, originates in mal-assimilation, and with good reason is commonly ascribed to a faulty secretion of milk on the part of the mother; but when once established, it is not remedied, as might be expected, by the withdrawal of the cause and the substitution of a different and less faulty food.”

Neumann (*Text-book of Skin Diseases*, translated by Pullar 1871, pp. 131 *et seq.*) does not give any separate account of infantile eczema, but merely alludes to it under the heading of “Eczema of the Scalp and Face.” Under the general ætiology of eczema he writes:

“Eczematous affections are *idiopathic* or *symptomatic*; the former arise from direct irritation of the skin, as from the action of irritant ointments. . . . the prolonged influence of extreme degrees of temperature, etc. . . . It is difficult to define the limits of temperature within which eczema is induced,

The origin of the symptomatic forms of eczema is more obscure. . . . to this category belong those eczematous affections dependent upon dyspepsia, which occur chiefly on the face and hands. . . . The relation subsisting between eczema and the rachitic and strumous diatheses is usually exaggerated. As the result of my statistics of 308 children affected with eczema, only thirty were rachitic, and seventy strumous, therefore, amongst 100 cases, 9·7 were rachitic, and 22·7 strumous. Again, more than 3000 strumous and rachitic patients came under my observation, amongst whom, not a single case of eczema occurred; we cannot, therefore, conclude that any great relation subsists between these two diatheses and eczema; further, the local treatment of eczema is successful, although these constitutional conditions exist. It is evident that only a small fraction of the cases of eczema occur in strumo-rachitic subjects, the majority being independent of any constitutional taint. . . . It may here be mentioned that the hereditary character of eczema, asserted by Veiel, is confirmed by my experience, only in so far that in certain families a predisposition to the disease exists, and that in such cases recurrence frequently takes place."

Tilbury Fox (*Atlas of Skin Diseases*, 1877, Plate XVIII, p. 31) writes :

"There is no difference in character between the eczema of children and adults. Eczema, moreover, occurs in the same seats and in the same forms in the young as in those who have passed the age of childhood. But the disease is so very common, in both public and private practice, about the head and face of children, that it is clinically of advantage to direct special attention to the disease, as it attacks these parts in the child. . . . The main exciting cause of this *E. infantile* is, without question, in the majority of cases in hospital practice, *defective*, and in private practice, improper, and even—though more rarely—*defective* feeding.

Also in another place (*Text-book of Skin Diseases*) he believes that it is identical with the disease in adults. He ascribes it to :

1. Mal-assimilation.
2. Delicate skin.
3. Acidity of secretion.
4. Irritants.

H. G. Piffard (*Morrow's System of Dermatology*, vol. iii, part i, pp. 250–252, 1894) states, under "The Hygienic Treatment of Eczema," that insufficient or improper food may be the chief unhygienic condition. This author reports a series of observations which he made as to the quality of the breast milk in a number of infants suffering from eczema, and in every instance there was a notable deficiency in the fatty matters. Even where the infant was plump he found benefit from the addition of cod-liver oil to the diet.

McCall Anderson (*Diseases of the Skin*, 1894), writes :

"It may occur in several of the same family, but usually only in one. It usually begins in the first six months, on the head or face, which it often leaves entirely. It is aggravated by teething. In Vienna it forms quite half the skin diseases of children."

He also quotes Schiff. (*Wien. med. Wochenschr.*, xiv and xv) as stating that the three important factors are :

1. Thinness of epidermis and superficial position of the blood-vessels.
2. Excessive turgor of infantile cutis.
3. Habitual hypersecretion of infantile glands.

Anderson does not appear to refer to the gastro-intestinal causes in this condition, but under the head of "Treatment" he favours dieting and various internal remedies in infantile eczema.

Bulkley (*Diseases of the Skin*, 4th edition, p. 206, 1899) writes :

"In treating nursing babies afflicted with eczema it is often necessary to treat the mother carefully by diet and internal medication, as a faulty condition of the breast milk is often at the bottom of infantile eczema."

J. F. Payne (article on Eczema in Allbutt's *System of Medicine*, vol. viii, 1899) includes infantile eczema in his general statements, and does not refer especially to the ætiology of this variety of eczema. His general views on the subject of ætiology include (1) vulnerability of the skin, (2) derangements of the nervous system, (3) auto-intoxication, (4) traumatism, (5) action of bacteria in the skin.*

Allan Jamieson (*Gibson's Text-Book of Medicine*, vol. ii, p. 411, 1901) writes :

"In infants the child may be plump and sturdy, or thin, pale and weakly."

Besnier (*La Pratique dermatologique*, 1901), who, to my mind, gives the most complete and elaborate account of the condition which exists in modern literature, referring to treatment, writes (p. 230, which I have ventured to translate) :

"Even though the types which have just been under discussion should be observed in their pure forms, none of them can be referred to in a single pathogenic condition which will serve to qualify it, so complex and composite is the pathogeny of the infantile eczemas. The knowledge of them can only serve,

* I shall have occasion to quote from this suggestive article later.

in any given case, to direct the doctor's attention towards the pathogenic and ætiological conditions, either local or general, the existence and exact nature of which it is necessary to ascertain in that particular case, in order to be able to deal with and check them.

"These indications are the first and most urgent to fulfil, and often, when this is done, one sees the eczematization, and the impetiginization rapidly improve, without any local treatment whatever, just as one sees local treatment fail, if the aforesaid indications are neglected. These indications have for their basis the setting right of the feeding and the functions of digestion and assimilation; they require, to be successful, a clear idea of all the conditions of nutrition in infancy, without forgetting to regulate everything which concerns the infant's nervous system, exciting reflex causes, dentition, etc., and all that goes to make up the hygiene of infancy—aeration, too warm rooms, etc."

Maffan (quoted by Besnier, *La Pratique Dermatologique*, *La Semaine Médicale*, March, 1894, p. 138), distinguishes two types due to different kinds of mal-assimilation.

1. Seborrhoeic eczema.

2. Dry eczema in scattered patches.

1. Begins on the hairy scalp, usually succeeding the common seborrhoeic crusts of sucklings. It covers the whole of the head, and there is much exudation. It then reaches the face and behind the ears. It sometimes reaches the neck and also forms the face mask. It may not be eczematous on the scalp if that is kept very clean, but only on the face. The pruritus is moderate. The children are often large and fat, and frequently have intertrigo. They are breast-fed.

2. The scalp usually escapes. It may be complicated with seborrhœa, but not seborrhoeic eczema. Affects cheeks, brow, chin, behind ears, umbilicus, and other parts of the body. Usually in hand-fed children, defective nutrition, dyspeptics, cachectic or rachitic.

Fagge and Pye-Smith (*Text-book of Medicine*, vol. ii, 4th edition, p. 830, 1902) write, under "Ætiology of Eczema":

"It appears to be waste of time to discuss the vague speculations, at once unscientific and unpractical, which ascribe eczema to such common disorders as dyspepsia."

Stelwagon (*Diseases of the Skin*, p. 298, 1902) writes:

"Over-feeding is occasionally a factor, though not so frequently as improper and deficient supply."

He agrees with Bohn ("Eczema," p. 133, in Gerhard's *Handbuch der Kinder Krankheiten* (Nachtrag), Tübingen, 1883), who placed great stress on obesity (*Fettsucht*) as a factor of infantile eczema in the first and second years, due to the character and the often unnecessary quantity of the nourishment given.

Also, under the heading of "Etiology of Eczema," he makes the following statements. Under "Heredity," he thinks, there is merely an hereditary tendency to irritable skin, most seen in blondes of the florid type, more in males than females, and especially in infancy and old age.

Under "Constitutional Causes"—he thinks dyspepsia and constipation are most important, especially in children, over-feeding, incomplete metabolism, improper food, imperfect oxidation, incomplete food supply; also "struma," especially in children; reflex effects of dentition: adherent prepuce, vaccination (which, however, is sometimes beneficial).

Under "External Causes" he classes all irritants, chemical, thermal, or mechanical, but says they often do not exist, or do exist, but are not recognised for a long time.

Radcliffe-Crocker (*Text-book of Skin Diseases*, 1903) says that one third of all cases in children begin in the first year of life. He refers to Unna's three varieties of infantile eczema—

1. Tuberculous (impetigo),
2. Nervous (due more to food than to teeth),
3. Seborrhoic, preceded by seborrhœa for some time;

but says that for himself he can draw no hard and fast line between the two. Of the so-called nervous form he says:

"Irritation of the alimentary canal from unsuitable food being the most frequent factor in the majority of cases."

To heredity he gives but slight claim. He further adds:

"In infantile eczema irritation and consequent catarrh of the alimentary canal is even more common as a cause of eczema than in older people. The imperfect feeding, of which infants are too often the victims, is a fertile cause of the skin troubles, and is much more often the *fons et origo mali* than teething, which for infantile diseases often takes the place of suppressed gout of the middle-aged: at the same time I cannot go so far as Hebra, who denies that it has anything to do with the matter."

Brocq (*Ann. de Dermatologie et de Syphiligraphie*, Tome iv, No. 3, 1903), under the title "L'Eczéma Considéré comme une Réaction Cutanée" gives the following *résumé*:

"Il y a des dermatoses caractérisées au point de vue objectif par des vésicules spéciales d'aspect: nous leur donnons le nom d'eczéma vrai, *quelle que soit la durée de la dermatose, quelle que soit son évolution ultérieure, qu'elle se développe*

d'emblee sur la peau primitivement saine, du moins objectivement, ou qu'elle se superpose d'une autre affection cutanée pré-existante."

"Ces dermatoses peuvent être provoquées par nombre de causes occasionelles chez certains sujets qui semblent y être prédisposés. On n'a pu encore y déceler un microbe pathogène. Nous sommes donc autorisé, jusqu'à plus ample informé, à les considérer non comme des maladies vraies, mais comme de simples réactions cutanées. L'organisme d'un sujet peut être orienté vers ce mode de réaction cutanée pendant des phases plus ou moins longues de la vie. Quand ces phases sont prolongées, ces périodes de réaction eczématisque correspondent à ce que nous avons appelé antrefois, avec les autres dermatologistes, la *maladie eczéma*."

He also classifies the infantile eczemas as follows, in four large divisions, which I have put in tabular form:

	I.	II.	III.	IV.
First ap- pears	2nd to 8th month	4th to 8th	4th to 8th	4th to 8th.
Situation	Face first, cheeks, forehead, temples, later, buttocks, limbs, extensor trunk, if severe	Scalp, ears, naso-labial, mouth, neck, anal fold, groins, articular folds	(a) Legs (severe); (b) face, arms (milder)	?
Characters	Minute vesicles on Eryth. base; "Ecz. vesic. vulg.;" successive crops; irritables; lichenification	Red areas, often nearly dry and squamous or moist, oozing; eczematized seborrhoides	Urticarial papulo-vesicular spots run together and form sheets, with true vesicular eczema on top; lichenification	Intense itching followed by vesicular eczema; lichenification.
General conditions	Faults of alimentation; neurotic parents	Fat, overfed, much improved by proper diet and local treatment	Arthritism of parents; neurotic intoxications (tea); lymphatism tuberculosis, syphilis	Alternate bronchitis or asthma.
Duration	Till 15 or 24 months old		Throughout life or till later childhood	3rd to 10th year.

W. B. Warde (*British Journal of Dermatology*, October, 1903, p. 365) writes:

If it can be established—and I think it can—that such agents as heat and cold are adequate to produce and maintain an eczema, and that the form produced depends on the agent that is acting, then it should also be possible to establish that other irritants, playing an important part in the production of eczema, could do the same, and that each form so produced could be distinguished from all the rest. The differential diagnosis would depend, not so much on the actual lesions, but on their grouping, time of appearance, behaviour, etc.

(To be continued.)

NOTES ON THE HISTO-PATHOLOGY OF MULTIPLE
IDIOPATHIC HÆMORRHAGIC SARCOMA.

BY J. M. H. MACLEOD.

IN the April issue of this Journal a typical case of the affection described by Kaposi in 1872 under the heading of "Multiple Idiopathic Pigment Sarcoma of the Skin," and later re-named more accurately "Multiple Idiopathic Hæmorrhagic Sarcoma" by the same observer, was recorded by Drs. Parkes Weber and Paul Daser, and a brief account of the microscopical appearances presented by two of the lesions was appended. Through the kindness of these contributors I have had the opportunity of making a further histological examination of the tissue excised from that case, and a few notes upon it may be of interest.

There is a growing tendency at present among certain observers—and it is doubtless a right one—to feel that in so far as the advancement of our knowledge of the ultimate causes and true nature of obscure affections of the skin is concerned, the value of the study of the histo-pathology of the lesions has definite limits, and that if we are to go forward it must be rather along the lines of physiological chemistry and the study of cutaneous reactions. They point out that to find a cause it is useless to study its effects, and to understand a living cutaneous reaction it is of comparatively little value to examine a dead tissue. Though this is clearly a step in the right direction, the histological field is by no means exhausted, and there is much yet to be learned from the study of the excised tissue. If I may quote a common aphorism, it is necessary to "creep before you walk," and in a considerable number of affections of the skin their pathology is still in the creeping stage. Among that number the disease under consideration may be placed; and in connection with its pathology there are various undecided problems, and the difficulties associated with the solving of them have rather increased than diminished since Kaposi first described its microscopical features.

The histological characteristics of the tissue examined from Weber and Daser's case were so typical of the disease as described by the majority of writers that a brief description of them will serve to refresh the reader's memory on the subject. The tissue consisted of two

lesions excised from the left leg ; namely (1) a small early lesion, from the left ankle, about the size of a split-pea, with a broad pedicle and removed so as to include a small portion of the surrounding skin, and (2) an older lesion, reddish-purple in tinge, about the size of the kernel of a small filbert nut, and excised from the left knee. This tissue was embedded in paraffin, and sections of it were stained by a variety of methods so as to demonstrate the cellular elements, the fibrous stroma, the elastin, and the pigment.

Lesion 1.—The epidermis enveloping the small tumour was attenuated, and the interpapillary processes flattened so that the line of junction with the corium had lost its usual wavy appearance. The individual cells of the Malpighian layer were flattened and slightly œdematous. The cornification process was impaired, and the stratum corneum was scaly. The condition of the epidermis evidently resulted from stretching due to the pressure of the underlying tumour-mass. At the side of the section where the tumour joined the surrounding skin the epidermis had proliferated and the interpapillary processes had been elongated, probably as the result of the irritation caused by the presence of the small growth.

The tumour-mass was situated in the corium and extended from immediately below the basal layer of the epidermis to about the middle of the reticular layer of the corium. It was roughly oval in shape and was definitely circumscribed, being separated from the surrounding corium by a dense layer or capsule of fibrous tissue, so that there was no actively spreading growing edge such as usually occurs in sarcoma. It was fibro-cellular in structure and markedly vascular, presenting here and there small sinuses lined by endothelium and containing breaking down hæmocytes and a few leucocytes. Similar deposits of hæmocytes and blood-pigment of a yellowish brown colour were present in the tissue spaces.

The fibrous stroma consisted of slender bundles and fibres of collagen, many of which were prolongations of the protoplasm of branching connective-tissue cells. These appeared to be young cells, and their fibrous processes united with those of other cells to form a network like that which occurs in young connective tissue. Near the epidermis attenuated collagen bundles were noticeable, in which the connection with cells could not be traced ; these stained badly and were probably old collagen bundles whose vitality had been impaired.

Another explanation of the fact that the collagen attracted stains feebly was the presence of œdema distending the tissue spaces and separating the fibres. The elastic tissue had completely disappeared from the centre of the mass, and only a few broken and curly fibres could be detected at the margins. In the surrounding stroma the elastin was present in its usual amount. The capillaries throughout the tumour-mass were dilated, and a few of them had become widened to form small sinuses. In several of the capillaries there was a definite endothelial proliferation, and in a few of the larger vessels the fibrous coats were thickened. The interepithelial lymphatics were also dilated. In the capillaries, sinuses, and lymphatic spaces the yellowish deposits of hæmocytes and blood-pigment already referred to were most noticeable. This pigment was almost entirely extra-cellular, though here and there its presence could be detected within the cells. A few of the capillaries had evidently become dilated to such a degree that they had burst, and the hæmocytes had made their way into the neighbouring tissue spaces and had there broken down.

The cellular elements of the tissue consisted chiefly of connective-tissue cells with large vesicular nuclei, which were defective in chromatin and attracted the stain feebly. Many of these cells were spindle-shaped, and possessed branching processes like the cells of young connective tissue. Mixed up with these were small round or polygonal cells with deeply-stained nuclei and a faint halo of protoplasm which appeared to be fibroblasts, and transition stages could be detected between them and the spindle-cells. In the neighbourhood of vessels a few mast-cells were noted. Both pilo-sebaceous follicles and sweat-glands were absent from the tumour-mass, but a number of sweat-glands were present in the unaffected corium beneath it.

Lesion 2.—The histology of the larger and older lesion resembled that described above in its main characteristics. There was the same general architecture with regard to the state of the epidermis, its relation to the tumour-mass, the fibro-cellular and vascular character of the mass, the presence of blood-cells and blood-pigment in the tissue spaces, and the absence of hair-follicles and sweat-glands. But the hypertrophy of the epidermis at the side of the tumour was much more pronounced than in the sections of the first nodule, and showed a tendency to hyperkeratosis and the formation of horny

pearls; and the cellular infiltration in the corium was dense in places, and its component cells more highly differentiated than those of the earlier lesion. Many of them were spindle-shaped with long narrow nuclei, which stained more deeply and were richer in chromatin than the larger vesicular nuclei. These cells were more allied to those which occur in a neuro-fibroma than in a spindle-celled sarcoma. There were also numbers of small fibroblasts and small roundish structures with deeply-stained nuclei which were probably spindle-cells in transverse section. The œdema in the sections of this lesion was also well-marked, and numerous polynuclear leucocytes could be detected here and there among the hæmocytes around a ruptured capillary.

Notes on the Histological Appearance presented by the Tissue examined with special reference to the Literature on the Subject.

One of the most noticeable features in the histology of the tissue examined was the marked vascularity of the tumour-mass. Numerous capillaries were present throughout, and some of these had become dilated to form sinuses, while a few of them had ruptured and allowed their contents to pass into the surrounding tissue spaces. In many instances the endothelium and even the perithelium had proliferated. Here and there were evidences of a new formation of blood-vessels. Associated with the dilatation of the blood-vessels there was considerable œdema, which distended the tissue spaces. The effects of this were evident also in the epidermis, where the process of cornification was interfered with, and scaliness occurred. Hæmocytes and blood-pigment were present in the dilated vessels and in the tissue spaces around them. Whatever the initial cause of the affection might be—whether a toxin or other irritant acting in association with a feeble peripheral circulation, or a micro-organism *in situ*—it seemed to attack the vessels first, causing a proliferation of the endothelial lining and the perithelium, a vascular dilatation and extravasation of blood, and a proliferation of the fixed cells in its zone of action. There was a certain degree of variety in the character of the cellular elements and stroma in the sections of the two lesions, and it may reasonably be assumed that this variation would be more marked in different cases, but as far as the present case was concerned it was more of the nature

of young organising connective tissue than of a sarcoma, or still less an "infective granuloma." The fact, also, that the tumour-mass was limited by a condensed layer of fibrous tissue and that there was no actively growing edge showed that in the stage of evolution of the tissue in the present case there was no malignant tendency, and argued against its being a sarcoma. The tissue in this case was more highly differentiated and stable than a sarcoma, and was even more highly organised than that of a neuro-fibroma. It suggested rather the type of tissue which occurs in the healing stage of the process of inflammation prevented from completely organising by the vascular stasis. But whether or not under other conditions such as the prolonged action of the irritant or an increase in its virulence the cells might not become less specialised, proliferate more actively, and revert to a sarcomatous condition could not be decided from the sections. To place it, however, in the ill-defined group of the "sarcoid growths" along with "multiple benign sarcoid" (Boeck), Sarcomatosis cutis, and Mycosis fungoides seems rather to beg the question, for in its histology it has little in common with Mycosis fungoides or Sarcomatosis cutis, and to judge from Boeck's own description differs considerably from "multiple benign sarcoid." Kaposi named and believed it to be a form of sarcoma primary in the skin, and composed of round and spindle cells. Unna supported Kaposi's opinion, and described the infiltration as fuso-cellular or angio-sarcomatous with abundant pigmentation, and named the affection "acro-sarcoma multiplex cutaneum teleangiectodes." In 1895 Perrin and Leredde suggested that it was a sarcoma of microbic origin, and in 1897 Campana made the observation that it began as a neuro-fibroma and became a sarcoma. In 1899 Bernhardt described it under the heading of "Angio-sarcoma periteliale fuso-cellulare," and again in 1903 corroborated his original opinion and referred to it as a spindle-celled angio-sarcoma. The belief in the sarcomatous nature of the affection is supported by a number of other writers, for example, Funk, Köbner, Schwimmer, and recently Halle. Various other observers as emphatically deny that it is sarcomatous, and suggest a variety of other possibilities. Spiegler, for instance, looked upon it as a transition stage between a chronic inflammatory disturbance and a sarcoma. Malherbe in 1897 placed it in a position intermediate between lymph-adenoma and lympho-sarcoma. Semenow

in the same year described it as a vasculitis or peri-vasculitis resulting possibly from the action of severe cold on the blood-vessels. In 1901 Bulloch, in his report on the histology of Sequeira's case, described it as a chronic inflammatory disturbance, and in 1902 Gottheil expressed the belief that it was made up of round connective-tissue cells which were not sarcomatous. Various writers such as Sellei have even gone so far as to describe it as a "granuloma."

A discrepancy such as this is partly explicable from the fact that the histological appearances in different lesions in the same case as well as in different cases vary considerably according to the stage of evolution of the lesions, their situation, and also as the result of individual peculiarities of the affected skin. But we must seek a further explanation for the great variety of opinion on the subject. This may be found in the fact that variations in the histological structure of lesions may occur without producing recognisable clinical differences, and not improbably that more than one pathological entity has been placed from time to time under the heading of "multiple idiopathic hæmorrhagic sarcoma."

It is useless to generalise from one case, and all that can be said with regard to the one under consideration is that, while presenting the typical clinical characteristics of the affection described first by Kaposi and observed repeatedly since, histologically, it was not a sarcoma but a growth of organising connective-tissue cells associated with marked vascular dilatation, œdema, and the deposition of blood-pigment.

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SOCIETY INTELLIGENCE.

THE DERMATOLOGICAL SOCIETY OF LONDON.

A MEETING of the above Society was held on Wednesday, April 12th, 1905, Mr. MALCOLM MORRIS in the chair.

The following cases and specimens were exhibited :

Dr. COLCOTT FOX exhibited the patient shown at the last meeting of the Society with the provisional and questionable diagnosis of *Prurigo*. At the time of the last meeting the patient was taking arsenic, prescribed by his medical attendant, and the drug had been continued until 4 minims of Fowler's solution were taken thrice daily. Dr. Fox recommended painting the whole body with the following cream :

R	Pulv. zinci oxidi	.	.	.	.	.	5ij.
	Lanolin anhydr.	.	.	.	.	.	5j.
	Ol olivæ						
	Aq calcis	.	.	.	.	āā	5ss.
	M. ft. cremor et adde—						
	Liq. carbonis detergentis	.	.	.	.		℥x.

When nearly dry the surface was dusted with potato starch powder so that a cleanly protective enamel was formed.

Under this treatment a remarkable amelioration had occurred, and the patient was completely freed from his eruption. He still experienced some itching after going to bed at night. The skin was considerably pigmented. The patient was obviously greatly improved in general health.

The exhibitor said he believed the eruption was really a peculiar phase of urticaria—a chronic urticaria with persistent prurigo-like papules, and he thought the coating of the skin with the enamel had effected the improvement.

Dr. GRAHAM LITTLE showed (1) a case of an *unusual granulomatous eruption* occupying the right upper arm of a young girl, aged 16 years. The eruption was shown by the exhibitor as being clinically identical with that shown under the above title by Dr. James Galloway at the last meeting of the Society, and this claim was allowed by all the members present. The history of the patient was that about three years or more ago the eruption, as now seen, came out. She was seen by the exhibitor at the Children's Hospital, Shadwell, nearly two years ago, and had then had the eruption about fifteen months. There were then four or five patches, looking a little like vascular naevi, but obviously not of this type, distributed upon the upper part of the right arm, and one on the upper part of the shoulder above the clavicle. The colour of these lesions, a deep brick red, could not be dispelled on pressure. There were no subjective symptoms at all, and the child, though a little anæmic, was otherwise in fair health. A younger sister was brought at the same time, suffering from psoriasis, but with this exception there was no family disease. The lesions were kept under observation for two years, and underwent no change in this time, except that that on the shoulder, which was the smallest and least marked of them all, disappeared spontaneously. The largest patch, which was about the size of a threepenny-piece, was excised two years ago, and sections of it were shown at this meeting. Although clinically the appearance suggested the presence of dilated vessels, none were found in the section, which showed a copious infiltration of round cells, in the papillary zone of the corium immediately under the epidermis. There was slight elevation, indicating microscopic papules, and the epidermis was thinned over some of these and normal or thickened over others; there was no enlargement of vessels in any part of the section. The infiltrated cells, upon examination with higher powers, proved to be round cells of the type of "daughter plasma-cells," and ordinary connective-tissue corpuscles. The infiltration ceased abruptly in a sharply demarcated line, the zone of infiltration being about as deep as the width of the microscopic

papules (about 50 μ in depth). The tissues below the level were perfectly normal. No trace of embolism could be seen in any part of the section, and the histological characters could not be anticipated from the clinical aspect of the lesions. No treatment was adopted (except the administration of iron for the anæmia) as it was felt that the diagnosis remained obscure. No fresh lesions had appeared since the advent of the original ones more than three years ago. The anæmia had been greatly benefited by treatment.

No diagnosis was offered of this unusual case.

(2) A case of *Urticaria pigmentosa nodularis* in an infant aged 9 months, and still at the breast, the rash having been noted at the first washing of the child after birth. All the lesions were raised from one eighth to a quarter of an inch, and of a peculiar cartilaginous firmness, from a quarter to half an inch in diameter in size, some round, and some irregularly polygonal; most of them were a deep buff colour, tending to brown; some of them, probably from recent irritation, were a vivid deep red. The distribution was very irregular, the nodules being scattered all over the body, but especially upon the back of the trunk, on the chest, the thighs, and the face and scalp. There was obviously much itching, factitious urticaria being easily demonstrated. The child was constantly crying, but was not obviously wasted or ill. The hardness of the lesions attracted particular attention, and the case was comparable to a *Xanthoma tuberosum* in the distinctness with which the nodules stood out from the skin; but the diagnosis offered was not dissented from by any member present.

(3) A case of *Nævus zosteriformis* in a female child, aged 6 years, with the following history: She had a severe "fit" at the age of 3 years, which was followed by paralysis of the right leg; three weeks later this eruption appeared upon the left side of the chest, and had persisted unchanged ever since that time, *i.e.* for three years. The eruption was made up of discrete flattened faintly-brown tumours, looking very like juvenile flat warts—for which, in fact, they were at first mistaken. They were finely lobulated, sessile excrescences, mostly about one eighth of an inch in diameter, and raised about one sixteenth of an inch or less. They were very numerous, about forty or fifty being arranged in a grouped manner, absolutely like that of *Herpes zoster*, one such group being in the position of the

innervation of the third dorsal segment above the nipple; another collection of small *nævi* was arranged in a more linear form, running out to the axilla along the anterior border of this; here the tumour became distinctly warty-looking (lobulated papillomata) and browner. Two very slightly raised and faintly brown lesions were seen on the upper and inner aspect of the arm, and a faint brown macule, probably raised to a microscopic degree, was seen below this again at the junction of the upper and middle third of the upper arm on the inner surface. All these positions are compatible with the innervation of the third dorsal segment, and the eruption seems rigidly confined to this metameric division. The resemblance to the typical distribution of *Herpes zoster* was very striking, and justified the French name of *zosteriform* in preference to "herpetiform," the use of which had become rather degraded and ambiguous.

Dr. J. J. PRINGLE showed a case of *alopecia, with scarring of the follicles*, details of which will be published in a future number of this journal.

Dr. SEQUEIRA showed a case of *congenital alopecia*. The patient was a healthy, well-developed girl, aged 3 years. The parents and their three other children were quite healthy and there was no history of a similar condition in any relative. The patient's scalp was covered with fine downy hairs, but was quite devoid of normal hair. Occasionally a few hairs would grow to the length of an inch or more and then fall out. The eyebrows were also wanting and the eyelashes were poorly developed. The condition had existed from birth. The child was bright and intelligent and showed no other abnormality.

Mr. GERALD SICHEL showed (for Sir Cooper Perry) a case of *Xeroderma pigmentosum* (Kaposi). The patient was a girl, aged 16 years, and had had the disease since she was 2 years, when she got "sun-burnt"; the sun-burn was soon followed by freckles, many of which became deeply pigmented. Besides the freckles her face was covered with minute scars, a fair number of telangiectases, and scattered warts.

On the left side of the left nostril was situated a fungating ulcer measuring about $1\frac{1}{2}$ by 1 inch. This had commenced in a wart some ten weeks previously. The skin of the whole of the face and neck

was markedly affected, also that of the backs of the hands, the extensor, and to a much slighter extent the flexor surfaces of the upper extremities, and slightly also the upper two thirds of the legs.

The patient held her head in a characteristic way, due apparently to slight photophobia; there were corneal opacities in both eyes, the result of "bad eyes" (corneal ulcers) when 3 years old. Slight vascular pterygium was also present. The scalp was dry and scurfy. The family history was good, no other case being known.

The case was being treated with X-rays, which so far had had a decidedly beneficial action, as the fungating ulcer on the nose had decidedly decreased in size, having previously measured about 2 by $1\frac{1}{2}$ inches.

THE DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.

A MEETING of this Society was held on Wednesday, March 22nd, 1905, Dr. H. WALDO in the chair.

The following cases were exhibited:

Dr. ALFRED EDDOWES showed two cases of *Lupus vulgaris* recently treated surgically by him.

No. 1.—A woman, aged 40 years, who had had numerous patches on her face, neck, and arms since infancy, was operated upon ten years ago by scraping and cautery. With few exceptions, the scars were quite free from disease. She had returned to this country for the treatment of a few fresh areas of disease at the borders of some of the scars. There was no trace of keloid in any of the scars; their colour was almost that of the surrounding skin, and they were everywhere level with the surface of the integument and perfectly movable. Many other forms of treatment had been used, but none had been so successful as surgical methods. The remains of disease had been recently thoroughly removed, and it was not likely that any fresh foci would form.

No. 2.—This was a case of a young woman who had suffered ten years from a patch on her face which had attained the size of over three inches long and an inch and a half wide, lying between the

right ear and the point of the jaw. Before Dr. Eddowes saw the case, for the first time two months ago, the patch had been treated by others in a variety of ways, so that some parts appeared cured while others were obviously spreading, and the whole patch was much sclerosed. It was practically impossible to do any good by scraping, and even cauterising with a low-temperature cautery was slow work, so Dr. Eddowes completely excised the patch, going well down into the subcutaneous tissue. The edges of the wound were approximated a little by means of sutures. The case was now shown to illustrate what an excellent scar had resulted. It was narrower than the original patch of disease, and it was level with the surface of the normal skin, and the exhibitor thought that he was justified in adopting the term "radical treatment" for this complete extirpation.

Dr. GRAHAM LITTLE showed (1) a case of *acute, circumscribed, wandering oedema* (Quincke's disease; giant urticaria), in a young married woman, aged 25 years, who had suffered for fifteen months, and had been under observation at St. Mary's Hospital for about four months. When seen at the meeting she presented an acute oedema of the left upper eyelid, which had swollen to the size seen during the journey from her home to the Society's rooms. In addition, she had two plaques of raised, reddened, and oedematous infiltration, one upon the arm, and the other upon the knee, about two or three inches in area. Patches such as these had been observed from time to time in the most varied positions upon the body, appearing and disappearing with almost bewildering frequency. She had marked dermatographia, but no very persistent itching. The teeth were very carious, and her tongue was frequently the seat of the so-called "glossitis migrans." An examination of the blood had been made in the pathological department with a view of testing the coagulation-time, and it was ascertained that this was double the normal average, so that the symptom of diminished blood-coagulability common in urticaria was certainly not present in this patient. No hereditary history was forthcoming to explain the case.

Dr. SAVILL stated that he had had four cases of this affection under his care during the last twelve months, and in every one the neurotic element was well-marked. They also exhibited tendencies to dermatographism and to morbid flushings.

Dr. STOWERS remarked that the infiltration accompanying the erythematous

patches often lasted many months. In one case he had seen the swelling was as large as a hen's egg. He was much struck by the condition of oral sepsis which prevailed in the case now exhibited, and he suggested the possibility of its bearing a causal relationship to the disease in question.

(2) A case of *universal alopecia in a boy aged 10 years*. The history was both interesting and unique. A younger sister of this patient had been seen for the same affection at the East London Hospital for Children, Shadwell, about four years ago. Her hair and eyebrows had completely disappeared, and had remained absent for many months. This patient had been brought up a little later with a commencing alopecia, which speedily became universal. This had persisted for some time, and then the hair had partially returned, but now it had again completely disappeared, there being universal alopecia at the present time, the eye-lashes, eyebrows, and lanugo hairs having been entirely shed. The sister was shown with the brother at the meeting. In her case, the hair had come back to a normal growth. There was no traceable neurotic history in the parentage. The age of this patient was unusually early for a complete alopecia, which was a rare disease in the opinion of the exhibitor.

Dr. PYE-SMITH stated that he had seen similar cases in children. He considered the prognosis bad as regards the restoration of hair, in spite of the previous history of a partial recovery.

Dr. NORMAN MEACHEN showed a married woman, aged 35 years, with *Tinea circinata of the face*. The patient had been transferred to him from the ophthalmic department of the Tottenham Hospital by Mr. R. Philip Brooks for an eruption of the face and lip, the eyelids being also affected. The lesions consisted of a trident-shaped elevation, radiating outwards from the right external canthus, the affected skin being reddened, infiltrated, and slightly scaly. There was considerable blepharitis. On the left portion of the upper lip was also a circinate, slightly scaly patch, fading away into normal skin at its lower margin. The appearance of the lip alone suggested a tertiary syphilitic eruption at first sight. Surface-scrapings from this region examined microscopically revealed the presence of a trichophyton with very fine, branching mycelium. The condition had lasted for nearly three weeks.

Dr. WILFRED WARDE remarked that some of these cases did occasionally

simulate a syphilide, and he suggested the possibility of infection in this case from a cat.

Dr. V. H. RUTHERFORD showed a man, aged 42 years, with *rodent ulcer*, which began twenty years ago, "like a cut," a little beyond and above the right angle of the mouth. The ulcer formed an irregular square, half an inch across, the portion nearer the mouth being superficial, while the further part was about one fifth of an inch deep. The edge was slightly indurated and undermined at the deep end. There was no history of syphilis. It was not painful, and there was neither enlargement of glands nor loss of flesh. Anti-syphilitic treatment had been tried for a time without benefit, but since the X-rays (nine sittings) had been employed improvement became apparent.

Mr. CYRIL A. RYDE showed a man, aged 31 years, married, the subject of *Acne necrotica*, and who also presented a condition of *multiple lipomata*. The acne lesions were situated upon the forehead and slightly on the chest. Scattered over the trunk and limbs were no less than thirty-five small tumours, varying in size from an almond to that of a small Tangerine orange. They were freely movable, and except those on the forearms, which had involved the *cutis vera*, were not painful, nor did they give rise to much inconvenience. He was muscularly well developed, but he admitted an excessive fondness for sweet articles of food of all kinds. The exhibitor had seen one other case in a young man, aged 27 years, who had thirty lipomata, and here, also, the same love for sweet things was manifested. There was no glycosuria in the present case.

Dr. T. D. SAVILL showed (1) a case of *vesicular erythema* of the hands in a woman, aged 54 years. The condition had lasted on and off for about five years. The skin of the hands was somewhat congested, but the chief lesions were seen upon the dorsum in the form of small, erythematous patches which, when first seen, were bordered here and there with minute vesicles. Her present health was fairly good, but she had suffered from gastric ulcer seven years ago. The exhibitor considered that it was often very difficult to distinguish cases of this nature from those of true *Lupus erythematosus*.

Dr. J. H. STOWERS inquired if there were any objection to the term "vesica-

ting," as he thought that this was more familiar than the one employed by Dr. Savill.

Mr. GEORGE PERNET considered that the case came more under the category of Erythema iris, especially as the lesions had been stated to be of a recurrent character.

(2) *A case for diagnosis.* The patient was a girl, aged 19 years, who presented a dry, cracked condition of the palms of about four years' duration. She was not in the habit of putting them frequently in water. Superficially, the case might have been regarded as one of Eczema rimosum, but on close inspection there was seen some actual keratosis affecting the palmar aspect of the fingers and about the lines of the palm itself.

Dr. P. H. PYE-SMITH believed that the condition was primarily an inflammatory one, the keratosis being a secondary phenomenon. He thought that the sweating complained of by most patients thus affected was merely an accompanying feature and not necessarily a precursor of the keratosis.

Dr. EDWARD STAINER showed a case of *extensive sclerodermia* in a middle-aged female. The disease first appeared three years ago and had since been steadily progressing. In addition to circumscribed patches on the limbs and neck, there was a wide band of affected skin completely encircling the trunk at the waist.

Dr. WALDO considered that itching was a very uncommon symptom in sclerodermia, and this patient complained of it a good deal. He thought it was rather an extensive case for the X-rays.

CURRENT LITERATURE.

**ACUTE INFECTIOUS PEMPHIGUS IN A BUTCHER, DURING AN
EPIZOOTIC OF FOOT AND MOUTH DISEASE, WITH A CON-
SIDERATION OF THE POSSIBLE RELATIONSHIP OF THE
TWO AFFECTIONS.** JOHN T. BOWEN. (*Journ. Cut. Dis., including
Syph.*, June, 1904.)

A WHOLESALE meat-cutter, aged 35 years, successfully vaccinated three months previously, cut his right hand in several places, and the part became swollen, and was opened surgically and dressed with sulpho-naphthol. The forearm showed signs of lymphangitis. Almost simultaneously the nose became swollen and crusted, with occlusion of the nostrils, and about fourteen days after the cut multiple yellowish "blisters" appeared on the head and ears and steadily extended over the body, accompanied by considerable prostration. He was

admitted to hospital about three weeks after the injury with a generalised pemphigus eruption. The temperature ranged between 101 and 103 degrees for two days after admission and then fell, and no new lesions appeared. The man made an uninterrupted recovery. The serum of the bullæ contained a few diplococci, and a culture from a lesion in the nose showed innumerable colonies of *Staphylococcus pyogenes aureus* and *Streptococcus pyogenes*.

Bowen refers to the literature of somewhat similar cases and compares them with the series of cases of acute bullous dermatitis observed in Boston after vaccination. He then discusses "foot and mouth disease" in cattle and man and shows the similarity of some cases to acute pemphigus. Whether or not the outbreak of "foot and mouth disease" in New England was started by the inoculation of impure vaccine virus, the work of Tyzzer proved conclusively that it might be disseminated by means of vaccination. Bowen considers the "bullous dermatitis following vaccination and resembling *Dermatitis herpetiformis*," which he described, quite a distinct affection.

T. C. F.

DERMATITIS EXFOLIATIVA NEONATORUM, OR RITTER'S DISEASE. ARTHUR J. PATEK. (*Journ. Cut. Dis., including Syph.*, June, 1904.)

THE author gives the history of a case in which he found intra- and extra-cellular diplococci in cover-glass preparations closely resembling gonococci, and these were reproduced in culture, but suffered some alterations in size. Patek has seen about twelve or fifteen cases. He considers the disease of septic origin. The discussion of the differential diagnosis is disappointing, for he mentions only Pemphigus foliaceus and acutus, and dismisses syphilis summarily. The contagious "pemphigus" of nurslings can be easily distinguished in the majority of cases, but there are conditions of more or less generalised erythrodermia, due to syphilis or forms of superficial dermatitis usually classed under Eczema seborrhoicum, which may present great difficulties in isolated cases. It is probable that sporadic cases are occasionally seen in London, but as our experience of the disease is not great, we may reproduce the author's summary of Ritter's observations. Professor Ritter von Rittershain observed from July, 1868, to 1878 297 cases, the majority occurring during the second week of life, some at the end of the first, and a constantly diminishing number from the second to the fifth week. The disease occurred in epidemics, but was not considered to be contagious. The following stages were noted:

- (1) *Prodromal*, consisting of dryness and branny desquamation of the skin.
- (2) *Erythematous*, varying much in degree, and usually beginning in the lower half of the face. Rhagades of the corners of the mouth form, the mucous membrane of the mouth becomes involved, and a descending generalised invasion of the tegument usually follows.
- (3) *Exfoliation*. Crusts form on the face. The trunk epidermis thickens and vesicles may form, or large areas of epidermis may be raised by a little serum or even separate without appreciable serous exudation, leaving a dark red and raw-looking surface, which may scab over. Manipulation of the body loosens the epidermis, wrinkles it into folds, and leaves the cutis exposed or covered with a non-protecting dead outer covering. The hands and feet suffer profoundly. Different stages of the process may be seen in various parts.

(4) *Regeneration* sets in by drying up of the surface and a branny desquamation. The whole process rarely lasts longer than from seven to ten days.

(5) *Sequelæ* may occur in the form of eczema-like conditions, furuncles, abscesses, and phlegmonous infiltrations. The general symptoms are frequently slight, though pneumonia and diarrhœa may occur.

T. C. F.

MYOMATA OF THE SKIN. W. A. HARDAWAY. (*Journ. Cut. Dis., including Syph.*, August, 1904.)

IN 1885 Hardaway (*Amer. Journ. Med. Sci.*, April, 1886) recorded a case of multiple myomata (microscopical examination) on the right side of the mid-dorsal region of the back in a man aged 36 years, of about one year's duration. The patient had recurrent neuralgic attacks in the same region, dating from before the growths were noticed. Pain was caused by deep pressure. The patch was excised, and Hardaway now gives the subsequent history up to the age of 54 years. The operation gave complete relief from the pains for eight or nine years. New growths have appeared in the original area and around and about, and in various other parts of the body. The various lesions cause spontaneous attacks of pain and pain on pressure, and intense burning, tingling, and itching.

T. C. F.

A PECULIAR ECZEMATOID ERUPTION OF THE LIP REGION.

HENRY W. STELWAGON. (*Journ. Cut. Dis., including Syph.*, August, 1904.)

STELWAGON discusses an eruption occasionally seen about the lips, with many aspects of eczema, but with distinctive features. It usually begins on the vermillion of the lips as a slight superficial eczematous irritation with scanty exfoliation or occasional slight crusting, without any liquid exudation. Any infiltration is slight. There may be burning and heat, but seldom troublesome itching. The eruption is apt to regress and reappear. It may extend somewhat on to the skin proper and then may present a definite border. Similarly the mucous membrane may be involved. Stelwagon has seen the tongue implicated. In the neighbourhood of the mouth one or more pea-sized, reddish, flattened or rounded, persistent, macules develop, becoming scaly. They may simulate a ringworm. In a few instances he found similar lesions on the scalp. On disappearance the lesions leave no traces.

Stelwagon says it is not syphilis, it is not a frank eczema, it is probably not Lupus erythematosus. Is it a phase of Eczema seborrhoicum? No fungus has been detected such as Wilmott Evans described. The most effective treatment is that for Eczema seborrhoicum.

T. C. F.

A SECOND CASE OF CREEPING ERUPTION (LEE), LARVA MIGRANS (CROCKER), HYPONOMODERMA (KAPOSI), DERMAMYIASIS LINEARIS MIGRANS ÆSTROSA (KUMBERG), WITH BRIEF REFERENCE TO THREE OTHER CASES UNPUBLISHED. HENRY W. STELWAGON. (*Journ. Cut. Dis., including Syph.*, August, 1904.)

THE author records a case in a male just returned from South America, whose attention was directed to a slight irritation on the dorsal aspect of the left foot and a slowly extending tortuous red line. By pressing a glass on the extreme

end of the advancing line and using a magnifying glass a minute grain-like, greyish-black speck or dot was detected. Attempts to secure the parasite were unsuccessful.

The cataphoretic application of corrosive sublimate solution for three days was without apparent effect, but progress was stopped, and the line faded away after the application of a minute droplet of nitric acid to the suspected site of the parasite.

The author also refers to three cases mentioned to him by Dr. Grover W. Wende, of Buffalo.

T. C. F.

REASONS FOR CONSIDERING DERMATITIS COCCIDIoidES AN INDEPENDENT DISEASE. DOUGLAS W. MONTGOMERY and HOWARD MORROW. (*Journ. Cut. Dis., including Syph., August, 1904*).

THE object of this paper is to bring out the points of distinction between Dermatitis coccidioides and blastomycosis, for the writers consider them distinct diseases. With regard to the name "D. coccidioides" they point out that the infection may not involve the skin, or be limited to the skin, and therefore the name "Dermatitis" is unsuitable. The organisms causing these diseases have many points of striking resemblance in their growth in the tissues and on culture media, and some of the vegetating lesions in each disease have a general resemblance. The points of difference recorded by the authors are arranged in the following table:

DERMATITIS COCCIDIoidES.

BLASTOMYCES.

The few cases on record are characterised by a great diversity in the clinical picture.	All cases bear a striking resemblance to one another.
The skin lesions, which resemble the rotten tomato-like lesions of the tuberous iodide of potassium eruption, may be scattered widely over the skin, or occur as subcutaneous abscesses; are frequently secondary to an internal infection, <i>e.g.</i> pleura or lungs, but may apparently occur primarily in the skin.	It always appears to be in the first place a disease of the skin. Miliary abscesses forming in the raised wall of the granuloma are characteristic.
It has no predilection for the outer surface of the lower eyelids.	It shows a preference for the outer surface of the lower eyelids, where it forms crescentic-shaped fungating sores.
It is at first a localised malady, but tends strongly to become generalised and end fatally.	It is always a chronic malady, with a tendency to remain localised to the skin, and with little tendency to metastasis and fatal issue (Busse's case is an exception).
The organism has a double cycle of growth without features in common, one in the tissues and one on culture media.	No such well-marked, absolutely distinct cycle of existence noted.
In the tissues the organism much resembles a coccidium and increases by endogenous spore formation, and budding has not been seen.	In the tissues the blastomyces multiplies only by budding.

- The commonest form of the organism, almost always perfectly circular, has a clear capsule with a double contour, enclosing a sphere of protoplasm having a granular dark periphery and a lighter, somewhat granular, centre. In another form the capsule encloses a vast number of small spherules, evidently due to endogenous spore formation, from which they escape on rupture. Empty and broken capsules are seen, from some of which non-clubbed ray-like filaments spread out in a fan shape. The latter is the only indication resembling a filament or mycelial thread seen in the tissues.
- In fresh specimens the double-contoured spheres may often be seen to be surrounded by a halo of short filaments like the cilia of ciliated epithelium.
- The organism is larger than blastomyces—often 30 microns in diameter.
- A hanging drop culture of a sphere from a drop of pus shows the outgrowth of a mycelial thread from one side of the capsule, and all the subsequent extra-corporeal growth of the organism is that of a fungus.
- On agar the aerial hyphæ are not high and furry; the growth is well circumscribed like a button in the media. Constantly grows faster, and liquefies gelatine more readily than blastomyces.
- Small spore bodies are present, but no double-contoured capsulated or budding forms have been seen.
- Inoculation into guinea-pigs of a fatal dose tends to attack testicles which become caseous.
- The administration of potassium iodide has no control over the disease.
- Shape frequently oval.
- Multiply in the tissues only by budding.
- No endogenous spore formation, unless the spherules in the peripheral protoplasm described by Hyde and Ricketts are so regarded.
- No filamentary outgrowths.
- No cilia-like halo.
- Average about 12 microns diameter.
- Nothing like this noted.
- In mature cultures the aerial hyphæ are very high frequently; the growth extends out into the surrounding media as a gradually diminishing haze.
- Budding forms characteristic and frequent, and capsulated bodies frequent.
- Not observed.
- Potassium iodide strikingly beneficial.

In the discussion following the reading of the paper at the American Dermatological Association, Gilchrist said that though he had been a party to christening the Californian disease *Dermatitis protozoica* he had accepted the fact since that these cases probably belonged to the blastomycetic group, and he now thought the authors' conclusions that the Californian disease was coecidial required experimental and scientific proof. Frank Montgomery thought the respective lesions clinically were not so distinctive, and mentioned two cases of blastomycosis in which the systemic symptoms preceded the cutaneous lesions by

several months, and again, three cases with subcutaneous lesions, and one case of systemic blastomycosis without cutaneous lesions. Typical metastases also had been demonstrated. Four fatal cases of blastomycosis were now on record. The cultural features must be taken for what they were worth. As a rule, the blastomycetic growth was quite uniform on a given culture medium, but differed considerably in different cases and on different media. In the majority of cases iodide of potassium improved cases up to a certain point, a little short of complete recovery. Nevins Hyde produced a drawing of a budding organism obtained by exposing culture tubes to a manure pile under the window of a room occupied by a man who developed blastomycosis.

T. C. F.

THE PATHOLOGICAL ANATOMY OF INDIAN MADURA FOOT (MYCETOMA PEDIS). M. OPPENHEIM. (*Archiv f. Derm. u. Syph.*, September, 1904, p. 209. Four plates.)

THE pathological material for this investigation of the Madura foot of India was obtained from the Tametsee-Djidjisbhoy Hospital in Bombay. Specimens of both the yellow and the black variety of the disease were examined and compared. The writer begins by carefully summarising the literature on the subject, and then describes the histology of the yellow and black varieties of *Mycetoma pedis* and compares them. Clinically and in their main histological characteristics they are practically indistinguishable. In both we have to deal with a granuloma made up of round cells, epithelioid cells, plasma-cells, and giant-cells. There is a tendency to abscess formation and necrosis in both, though the black varieties seemed to be more apt to form abscess and liquefy than the yellow type, while in the yellow variety there was a greater tendency to form new connective tissue. Hyalin degeneration (or Russell's fuchsin bodies, as the writer calls it) occurred in the yellow type, but was absent in the black mycetoma.

With regard to the fungus which caused the two varieties, there is, according to the writer, the greatest difference, for in the case of the yellow mycetoma the fungus is closely allied to the actinomyces, while in the black variety it seemed to be more of the nature of an oidium.

J. M. H. M.

FURTHER CONTRIBUTION ON THE CLINICAL AND HISTOLOGICAL CHARACTERISTICS OF ERYTHEMA INDURATUM OF BAZIN. HARTTUNG AND ALEXANDER. (*Archiv f. Derm. u. Syph.*, September, 1904, p. 384. Three plates.)

FIVE cases of Erythema induratum are reported in this communication. These occurred in the Dermatological Clinic of the General Hospital at Breslau. The patients were all adults and three of them were males. The clinical characteristics as well as the histological architecture of the lesions were similar in all the cases. The extremities alone were involved, and the lesions consisted of the familiar deep-seated nodules, covered by tense bluish-red skin, and tending to necrose. In one of the cases, an injection of 2 mg. of the old tuberculin resulted in a definite local reaction and a slight general reaction. In another case there was a general reaction, but no local effect from the tuberculin. Histologically the changes were most marked in the subcutaneous tissue, where foci of cellular infiltration, made up of lymphocytes, epithelioid cells, and giant-cells,

were present, chiefly located around the blood-vessels. The appearance of the foci was identical with that of circumscribed tuberculous foci.

The writers believe that Erythema induratum is a tuberculous affection of the skin of hamatogenous origin and is essentially an arterial embolic condition. They refer to the similarity except in point and size of the lesions in "folliclis" and Erythema induratum and regard the two affections as variants of the same pathological process. The paper concludes with a *résumé* of the literature on the subject. It is illustrated by three coloured plates showing the histological appearances.

J. M. H. M.

ON LICHEN ATROPHICUS AND OTHER MACULAR ATROPHIES OF THE SKIN. W. WECHSELMANN. (*Archiv f. Derm. u. Syph.*, September, 1904, p. 333. Two plates.)

IN 1887 Hallopeau gave the name of Lichen planus atrophicus to the variety of Lichen planus in which there is a marked tendency to atrophy of the lesions, which become replaced by white scars varying in size from a linseed to a 5-mark piece, the surface of which is either smooth, or scaly, or may occasionally be punctiform from the openings of hair-follicles or glands. The border of these atrophic lesions is either red and made up of a conglomeration of Lichen planus papules, or it is hyperpigmented. The lesions have a predilection for the forearm, but may occur anywhere on the trunk and extremities, and the mucosa may be involved. Cases of this type have been carefully recorded also by Zarubin, Reiss, and others. In this contribution the author describes a case of a male, aged 35 years, who suffered from it. The lesions began on the left temporal region and on the forehead as discrete erythematous papules about the size of a pea. The disease spread from there on to the back. When the lesions involuted they left white atrophic spots, the surface of which was grooved. A few of them had a raised wall round them, while in others the border was pigmented; there was no itching associated with the lesions. A lesion was excised from the back and examined histologically. The epidermis and papillary and subpapillary layers were alone affected. The epidermis showed a marked thinning and flattening of the interpapillary processes, and the prickle-cells seemed to have become pressed together so as to form an almost homogeneous layer. There was an infiltration of cells in the papillary and subpapillary layers, consisting chiefly of lymphocytes, and neither plasma-cells nor mast-cells were noted. There was a certain amount of œdema of the connective tissue in the infiltrated area, and the elastin had undergone a degeneration into elacin.

The literature on the subject is fully discussed and a bibliography is appended.

J. M. H. M.

RARE CASES OF SKIN DISEASES. Collected by LA MENSA. (*Archiv f. Derm. u. Syph.*, September, 1904, p. 324.)

THE four cases the notes of which are reported in this contribution occurred during last year in the clinic of Professor Tommasoli of Palermo.

Case 1 was an instance of the rare affection known as *Dermatolysis*. The patient was a female infant aged 2 months, and the peculiar affection of the skin was noted at birth. The child was born at full time. A photograph illustrating

the case shows large folds of the lax skin pinched up on the back, neck, and scalp by the nurse in holding the child. The skin of the rest of the body seemed to be normal in thickness and consistence. Another peculiarity of the affected skin was the fact that the lanugo hair over it was more deeply coloured than that of the neighbouring skin. On the left side of the neck there was an ovoid tumour about the size of a small nut. The writer discusses the literature on the subject.

Case 2 was one of *primary lupus of the palms of the hands*. The patient was a man aged 23 years, and the subject of *Lupus verrucosus* of the palms of both hands. When 5 years of age he suffered from a caseating lymph-gland on the neck. After this was operated on foci of lupus developed on the face and shoulder. A year before he came up for examination, after the lupus had been in existence for 15 years, the affection of the palms had appeared. It next developed on the leg and back. The special interest of the case lay in the very unusual situation of the lupus, on the palms of the hands.

Case 3 was a case of *linear warts*, situated on the calf of the right leg in a man aged about 40 years. He had had a similar affection about the right shoulder, which had disappeared after a few months leaving pigmentation. The lesions on the calf consisted of small linear warts about 2 mm. in breadth and forming parallel and vertical lines 6 to 8 cm. in length. The surface of the lesions was slightly scaly, and their consistence was soft. The surrounding skin was unaffected. Outside these warty lines were other vertical lines which were not warty, but simply pigmented, and occupied the site of previous warty lesions. The lesions were itchy. The writer considered them to be soft warts and not an instance of hypertrophic *Lichen planus* which the appearance of the lesions in the accompanying photograph strongly suggested.

Case 4 was a patient suffering from a nodular patch of *Lupus vulgaris of the chin*. Photographs of the various cases serve to illustrate the paper.

J. M. H. M.

MULTIPLE NEUROTIC GANGRENE OF THE SKIN. LATTE. (*Monatsh. f. prakt. Derm.*, August 15th, 1904, p. 189.)

THREE cases are described, the patients being girls aged 22, 23, and 19 years respectively. In all three cases Latte holds that the lesions were artificially produced. In two of the patients there were symptoms of anæmia, anomalies of menstruation, anæsthesia, and analgesia. In the second case the gangrene was started by an injury with an iron, and was associated with chemical irritation by soda solution. Later on no doubt the patient produced gangrene in previously healthy portions of skin by rubbing and the application of solution of soda. In the first case the motive was in all probability the patient's desire to make herself interesting. In two cases there was an unusual tendency to keloid formation, but this was probably due to the patients' interference with the wounds while healing. The cases are to be distinguished from those described by Kaposi as *zoster gangrænosus hystericus*.

J. L. B.

MULTIPLE NEUROTIC GANGRENE OF THE SKIN. BRANDWEINER. (*Monatsh. f. prakt. Derm.*, September 1st, 1904, p. 241).

THE patient was a female, aged 31 years, who had suffered with hysteria from the age of 13, and had been treated several times in asylums. The skin affection had been present for four years, with intermissions. It began on the leg, spread

to the buttocks, the upper extremities, and finally the face. During the whole of this time lesions reappeared on portions of the skin which had been previously affected, and even on the scars. The usual course was for the affection to begin on a small circumscribed area, with itching, burning, or pricking sensations. Sometimes the area became red and swollen and developed vesicles; sometimes the vesicles made their appearance on apparently healthy skin. The interval between the occurrence of the subjective symptoms and the vesicles was sometimes very short—in one case three minutes. Occasionally the vesicles were arranged in the form of a crescent, but most usually they formed a circle, separated from the central diseased portion of skin by a narrow strip of apparently healthy cuticle. The vesicles ran together to form bullæ as large as beans, with no zone of inflammation round. Very quickly, within a few hours, gangrene set in, appearing first on the floor of the bullæ, but afterwards involving the whole of the affected area. The scab was at first moist and greyish-green, betraying its development out of confluent vesicles only by its wave-like peripheral margin. As it dried the scab became more like leather and darker. Surrounding the scab was a narrow, inflamed edge which gradually increased. After four to six weeks the scab was shed, granulation took place and new epidermis grew in from the edge. The scars were at first fairly vascular, pinkish, smooth, not hypertrophic, not keloid.

Microscopical examination showed the bullæ to be either subcorneal or intra-epidermoid. Their covering consisted either entirely of the stratum corneum or the same associated with pathologically changed portions of the malpighian layer. The bullæ were unicellular, and filled with serum, containing exudation and degenerated epithelial cells. The earlier lesions, therefore, showed some resemblance to those of herpes zoster, and the late lesions always gave the picture of gangrene, without apparent differences from that due to burns or scalds. The gangrene was quite a superficial one; it began under cover of the bullæ, or its contents, attacking first the upper layers of the rete and remaining chiefly localised to them.

Bacteriological examination gave an entirely negative result.

Intra-cutaneous injection of the clear fluid of the bullæ at midday gave rise to a lesion in the patient, which increased and towards evening showed several vesicles. Next morning these vesicles had coalesced to form a bulla, whose floor was already quite necrotic. Round this bulla smaller vesicles developed in a circle. Similar injections into the patient of distilled water and air caused no gangrene, but injection of serum obtained from her own blood once caused gangrene in her similar to the above.

Control experiments on the patient caused no gangrene.

Therapeutic treatment was useless.

J. L. B.

XANTHOMA DIABETICUM TUBEROSUM MULTIPLEX. DERLIN.
(*Münch. med. Wochenschr.*, September 13th, 1904, p. 1636.)

A MALE, aged 42 years, a diver; his term of military service had been cut short by rheumatism, from which he had never entirely recovered. Twenty years before he had an ulcer on the penis, which healed without any special treatment. In October, 1901, small nodules appeared on the back of each wrist, and then in succession on the elbows, shoulders, buttocks, and knees. He had complained of great thirst for many years. In November, 1903, when he came

under observation it was noticed that he was a huge and muscular man. The eruption was present on the parts mentioned, and showed a tendency to follow the course of the superficial nerves. The nodules projected sharply; they showed a yellow conical centre with a red margin. There was slight swelling of the glands beneath the jaw, in the neck, and groins. The eyelids, face, and neck were free. The urine contained 3 per cent. of sugar. By the end of December the sugar had disappeared, and, with the exception of two strings behind the elbows, the eruption also.

Neglect of dietetic precautions led to a reappearance of the sugar and eruption; but these disappeared again on resumption of the diet ordered. There still remained a thick infiltration behind each elbow.

Histologically the nodules were found to consist of wavy bands of fibrous tissue, enclosing spindle and round cells. In frozen sections the cells appeared crammed full of drop-like yellow granules. Methods for fat staining showed that the fat was not only included in the cells, but that it had escaped and rested in layers between the cells. In the stage of involution all the fat had disappeared.

The author compares his case with others that have been described, and shows that all were corpulent men, from thirty to forty years old, suffering from glycosuria. In all the face remained free, the parts affected being the extensor surfaces of the extremities, particularly near the joints; the dermatosis was favourably influenced by dietetic treatment and inclined to relapse when this treatment was not properly observed. In all these respects these cases differ from *Xanthoma planum*.
W. B. W.

TUBERCULOSIS, DUE TO INOCULATION WITH THE MORPHIA SYRINGE. OSKAR BRUNS. (*Münch. med. Wochenschr.*, September 13th, 1904, p. 1643.)

AMONGST many instances in the literature of tuberculosis of the skin caused by accidental inoculation, as by instruments, splinters of wood, earrings, etc., the author found four cases in which the hypodermic syringe was responsible. The four cases are quoted briefly, the clinical type in each instance being different. A full description is given of a case observed by himself.

The patient, a man suffering from tuberculosis of the lungs, was accustomed to inject himself frequently with morphia. His method was to moisten the place he intended to inject with his saliva, and to insure that the needle was free by blowing through it. For six months no evil resulted, and then red papules, from the size of a pin's head to a linseed, began to appear on various parts of the abdomen and thighs. In a few days these formed yellow vesicles. The vesicles dried into crusts, beneath which were rounded ulcers with irregular, undermined edges. In a few weeks some fifty ulcers had formed. Then a number of subcutaneous nodules appeared on the abdomen and breast, varying in size from a pea to a plum. These in some instances softened and discharged yellow pus.

Pus taken from these subcutaneous nodules gave rise to tuberculosis in three guinea-pigs experimented upon, and the histological structure of the nodule was tubercular; but there is no evidence in the paper to show that the superficial ulcerating papule first described was investigated. The patient sank steadily and died.
W. B. W.

CANCEROUS DEGENERATION OF ATHEROMATOUS CYSTS.

DENIS G. ZESAS. (*Münch. med. Wochenschr.*, September 13th, 1904, p. 1647.)

A WOMAN, aged 68 years, for twenty years had had atheromatous cysts on the scalp. During the last five years these had ulcerated. When she came under observation there was extensive cancerous ulceration of the scalp. The glands behind the left ear and under the jaw on the left side were swollen. The whole growth was removed; but the patient steadily grew weaker and died four weeks after the operation, from pneumonia.

W. B. W.

RECURRING HERPES ZOSTER, WITH A SPECIAL REFERENCE TO ZOSTER ERYTHEMATOSUS, AND ZOSTER VEGETANS.

HANS VÖRNER. (*Münch. med. Wochenschr.*, September 27th, 1904, p. 1735.)

THE impression that recurrences of Herpes zoster are uncommon is not supported by a reference to the literature of the subject in which a great number of instances are recorded. Various attempts have been made (Lendet, Grindon, Fabre) to classify these cases. The author reviews these attempts, and expresses the opinion that the cases of Zoster gangrænosus recidivus atypicus hystericus included by Grindon, as also Herpes labialis and genitalis, and probably Herpes chronicus, do not resemble typical herpes in many important particulars. There then remain only: (1) Cases where the disease reappears on the part previously affected; and (2) cases where it appears in succession on other parts of the body. With this reservation the recorded cases are far less numerous.

The author records a case of his own of recurring herpes of the area supplied by the great auricular nerve, and then goes on to remark that as in typical herpes some parts of the eruption may not develop vesicles, but remain as clustered red papules or erythematous patches, so these may at times be the only manifestations of the disease. A number of interesting observations are reported in support of this. He concludes by describing, under the name of Herpes vegetans, a case in which the eruption affected the buccal mucous membrane. The first attack was vesicular, but the second and third led to a granulomatous elevation of the affected part. Two other cases of a similar nature, reported by other observers, are given.

W. B. W.

NEW RESEARCHES ON THE ORGANIC EXCHANGES IN LICHEN PLANUS AND ON THE MODE OF ACTION OF ARSENIC.

RADAELI. (*Ann. de Derm. et de Syph.*, May, 1904, p. 399.)

FROM an extremely close and careful study of six cases, of which five are reported *in extenso* here, Radaeli thinks he can make the statement that the eruption of Lichen planus diminishes *pari passu* with the amount of nitrogen escaping in the form of urea, as compared with the amount of nitrogen voided in other ways. He has found that the ratio of the urea-nitrogen to the nitrogen otherwise excreted diminishes with the pushing of arsenic, and is at its minimum when the eruption is fading. This parallelism suggested the study of the following problems, namely: What are the nitrogenous substances which are increased at the moment when the percentage of urea-nitrogen diminishes? and secondly, to ascertain whether this exchange of nitrogen is caused by arsenic in Lichen planus alone or in other conditions treated with arsenic. Details of the

methods used are given, and are too long to quote here; it will suffice to mention that the writer considers that the action of arsenic which is responsible for the diminution of the eruption is linked with the increase of the nitrogen in the form of amido-acids, at the expense of the nitrogen of urea. It must be noted that the arsenic is given as hypodermic injections of arseniate of soda, in quantities of from 1 to 3 milligrams to begin with, but increased in some cases to 9, 20, 30, and even 72 milligrams! these larger quantities being given after intervals of freedom of a week or longer. An experiment was undertaken in two cases, not Lichen planus, to ascertain whether the same conditions were observed in other dermatoses than lichen in which arsenic was administered. One case, of Kaposi's disease (cutaneous hæmorrhagic sarcoma) and the other, of psoriasis, were treated with injections of arsenic. It was not possible in these cases to establish whether the involution of the eruption coincided with the diminution of urea-nitrogen, but it was established that the administration of arsenic diminished the proportions of urea-nitrogen, while increasing that of the amido-acids. The same phenomenon of decrease of urea-nitrogen, with corresponding increase of nitrogen in the form of amido-acids, is observed in cirrhosis of the liver, and in phosphorus-poisoning; and the author suggests that the action of arsenic as above detailed may result from its influence on the urea-forming functions of the liver. E. G. L.

LIST OF BOOKS, PAMPHLETS, ETC., RECEIVED.

From JOSEF SAFÁR, Vienna, 1905. *Results of 240 Cases of Lupus Treated by Operation*. By LUDWIG SPITZER and Dr. ALFRED JUNGSMANN. Price 6.50 marks.

From ALFRED HÖLDER, Vienna, 1905. *Introduction to the Microscopical Study of the Normal and Diseased Skin*. By S. EHLMANN and JOH. FICK.

From the GRAFTON PRESS, New York, 1904. *Transactions of the American Dermatological Association*. Official Report of the Proceedings. By CHARLES J. WHITE.

From REEMAN COMPANY, London, 1905. *The Effects of Tropical Light on White Men*. By Major CHAS. E. WOODRUFF, A.M., M.D. Price 10s. 6d. nett.

From HENRY KIMPTON, London, 1905. *Diseases of the Skin*. By JAMES NEVINS HYDE, A.M., M.D., and FRANK HUGH MONTGOMERY, M.D. Price 25s. nett.

From E. H. BLAKELEY, London, 1905. *The Diagnosis and Treatment of some of the Common Diseases of the Rectum and Anus*. By CECIL H. LEAF, M.A., M.B., F.R.C.S. Price 3s. 6d. nett.

THE BRITISH JOURNAL OF DERMATOLOGY.

JUNE, 1905.

THE AGE-INCIDENCE OF HERPES ZOSTER.

By WILLMOTT EVANS, M.D., B.S., B.Sc., F.R.C.S.,
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IN the chief text-books of dermatology there exists a great diversity of opinion as to the age at which Herpes zoster is most frequently to be met with, and this diversity is not to be explained by any misunderstanding as to the disease to which the name "Herpes zoster" is to be applied, or any confusion with the several other morbid conditions of the skin to which at one time or another the term "herpes" has been affixed. Herpes zoster is easily to be diagnosed by everyone possessing anything more than a rudimentary acquaintance with dermatology, and, therefore, the difference of opinion must have some other cause. To show that this diversity of opinion does exist it will not be necessary for me to quote from all, or even from the greater number, of those who have written on the subject, but I will cite a few as illustrative of the whole number. Of the earlier writers the majority do not appear to have noticed any special frequency of occurrence at any one period of life, or at least they have not considered it worthy of mention in their treatises. Bateman (*A Practical Synopsis of Cutaneous Diseases*, by T. Bateman, sixth edition, 1824, p. 232) does refer to the age-incidence of the disease, for he says: "Young persons from the age of 12 to 25 are most frequently the subjects of the disease, although the aged are not altogether exempt from its attacks, and suffer severely from the pains

which accompany it." This statement hardly agrees with that enunciated by Rayer (*A Treatise on the Diseases of the Skin*, by P. Rayer, second edition, translated by R. Willis, 1835, p. 257), for he says: "Adults are more frequently attacked than children and elderly persons."

Coming to more recent days, we find Hardy, in 1886, writing (*Traité Pratique et Descriptive des Maladies de la Peau*, par Alfred Hardy, 1886, p. 243): "Le zona se developpe à tous les âges, à peu près également, sauf pour la première enfance, dans laquelle on en observe peu d'exemples."

I will quote a few recent text-books. Radcliffe-Crocker says (*Diseases of the Skin*, third edition, 1903, p. 234): "In my practice three fourths of the cases were under 20 and two thirds of these under 13 years; nearly all the rest were over 40." H. W. Stelwagon (*Treatise on Diseases of the Skin*, third edition, 1904, p. 333) writes: "Herpes zoster occurs in both sexes and at all ages; although uncommon in the very young, still, it has exceptionally been observed in early infantile life. It is probably most frequent in those between the ages of 10 and 30."

Perhaps the most valuable contribution towards the solution of this question is to be found in the work of H. Head (Clifford Allbutt's *System of Medicine*, vol. viii, p. 617). He says: "I find that out of 378 cases 283 were under the age of twenty-five, 66 between twenty-five and fifty years, and 29 over fifty years. If these cases are arranged on a chart the maximum incidence between the ages of twelve and thirteen is beautifully seen. Broadly speaking, the age at which the disease is most apt to occur lies between three and twenty, with a more particular proneness to attack between four and thirteen."

It is thus clear that observers are not agreed as to the ages when the disease is most prevalent, and that the diverse opinions are not founded on mere general impressions, but on statistics. Head suggests that the small number of cases seen by any one observer will serve to account for the discrepancies which exist, and no doubt this explanation will serve in part, but it is more probable that there are other factors. On examining the several opinions, we see that, while some hold that the disease affects persons of all ages fairly equally except in early infancy, and others say that adults are more frequently attacked

than children and elderly persons, others consider that the disease is most apt to occur between the ages of 3 and 20.

From the consideration of the statistics founded on the cases which have been under my own observation, I find that half of all my cases were under 14 years of age, and this result agrees almost exactly with Radcliffe-Crocker's statistics, for he found that half of his cases, (*i.e.* two thirds of three quarters) were under 13 years of age. Further, I find that over the age of 40 there are many cases amounting to about one sixth of the whole number. This also agrees closely with the opinion of Radcliffe-Crocker, that after deducting the cases occurring under the age of 20, the majority of the remainder were over 40.

In Fagge and Pye Smith's *Text-Book of the Principles and Practice of Medicine* (third edition, p. 940) it is stated that among 100 consecutive cases of the disease 46 occurred under 20, and 25 over the age of 40 years. Thus, according to the statistics of my cases, there are two periods of life when Herpes zoster is especially likely to occur. In the first place, it is liable to be seen in patients under 14 years of age, but there is, secondly, a great likelihood of its occurrence later in life, say after the fortieth year.

Is it possible to explain the very marked divergence of the opinions expressed, and if so, how?

It is a fairly safe rule that, when in any disease there are two distinct periods of incidence, there are two distinct etiological factors, or two separate diseases have been confused.

It is important to bear in mind, firstly, that different sets of statistics frequently refer to different localities or to different classes of the community. In favour of this view is the relative frequency of occurrence of Herpes zoster. In the statistics collected by the American Dermatological Association the frequency of Herpes zoster is given as 1·15 per cent. With this we may compare the percentage found by Radcliffe-Crocker in 10,000 out-patients; in these Herpes zoster amounted to ·61, while amongst the private patients of the same observer the frequency was only ·36 per cent. These great variations show that locality is probably responsible for some of the differences. Herpes zoster does not occur equally in all parts of the country nor in all ranks of society. In epidemics of the disease—and that epidemics do occur all will acknowledge—the disease is

almost confined to children, and thus in places where the disease is especially liable to occur in epidemics the proportion of cases in children will be unduly exalted. Another very important factor is, in my opinion, the multiple origin of the disease. There is much reason for thinking that a large majority of the cases of Herpes zoster are really microbic in origin; the chief arguments in favour of this view are, firstly, the occurrence of epidemics, and secondly, the seasonal prevalence of the disease. This microbic variety may be looked upon as the essential form of the disease, simulated by the cases of other etiology. These other cases may be produced by such widely separated causes as arsenic, trauma, and tuberculous meningitis. With so varied an etiology it is inevitable that great discrepencies must occur in different series of statistics. The question then arises, Can we assign to different causes the different groups of Herpes zoster which some statistics have shown to exist? I think we may, with some hesitation, attribute most cases of the disease occurring in children to the microbic form, while those cases which occur after 40 will naturally fall in another etiological group, though the exact cause cannot yet be determined. We have in the symptomatology a very strong argument in favour of this broad division of Herpes zoster. In children the disease is very rarely painful, and any pain that has been present disappears promptly with the eruption. With those more advanced in years, say over the age of 40, the case is far otherwise. Not only may the eruption be preceded and accompanied by severe neuralgic pain, but long after the vesicles have scabbed and healed the pain may persist with agonising intensity. Moreover the severity of the pain and the extent of the lesion bear no sort of relation to one another; in fact, the greatest pain is often experienced when the skin lesion is but slightly marked. This difference in the severity of the pain points, I would suggest, to an etiological difference. I think I have advanced sufficient reasons for thinking that under the name Herpes zoster we have grouped together several distinct diseases, distinct, in their etiology and in their course. On one other point I should like to say a word. In no book have I been able to find a reference to the preponderance of women in the cases of Herpes zoster occurring after the age of 40. In my own cases more than 75 per cent. were women. It is true that in various text-books reference is made as to the relative

frequency with which the two sexes are affected by the disease, but these numbers refer to the disease at all ages, and are therefore valueless for comparison with my experience of patients over the age of 40 years.

AN INQUIRY INTO THE ETIOLOGY OF INFANTILE ECZEMA.

By ARTHUR J. HALL, M.A., M.D., F.R.C.P.,

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(Continued from page 172.)

SECTION III.—AN ANALYSIS OF SIXTY CASES OF INFANTILE ECZEMA, WITH COMMENTS.

TABLE OF CONTENTS.

(a) . Sex (Chart No. 3).

FAMILY HISTORY.

(b) . Age of mother (Table I, Chart No. 4).

(c) . Number of other children, etc. (Table I, Chart No. 5).

(d) . Evidence of skin disease (past or present)
in parents. (Table II, Chart No. 6).

(e) . Evidence of skin disease (past or present)
in other children (Table I, Chart No. 7).

DETAILS REGARDING FIRST APPEARANCE OF ERUPTION.

(f) . Age of child. (Table III, Chart No. 8).

(g) . Site (Table IV, Chart No. 9).

(h) . Season of year (Tables VIII and IX, Charts
No. 1 and 2).

(i) . Nature of food (Table III, Chart No. 10).

DETAILS AS TO VACCINATION AND DENTITION.

(j) . Vaccination (Table V).

(k) . Dentition (Table V).

CONDITION OF CHILD WHEN FIRST SEEN.

(l) . Evidences of alimentary disturbance or
rickets (Tables VI and VII,
Charts Nos. 11—14).

(m) . Character and distribution of eruption . (Table IV and special
diagrams).

(n) . Summary

(a) SEX. (*Vide* Chart No. 3.)

Of the sixty cases, forty-seven (78·3 per cent.) were males; thirteen (21·7 per cent.) were females.*

(b) AGE OF MOTHER,† (*Vide* Table I and Chart No. 4.)

It will be seen from Table I that the average age of fifty-five mothers is twenty-nine years.

The details are as follows :

Age of mother.	No. of cases.
Below 25 years	16
Above 25, but under 30 years	17
.. 30, .. 35	12
.. 35 years	10
	<hr/> 55

Or

Below 25 years	16 (29 per cent.)
Above	29 (71 per cent.)

It must be remembered that the usual time for marriage in the class from which these cases are taken, is at a very early age, probably under twenty years.

(c) NUMBER AND RELATIVE AGES OF OTHER CHILDREN, ETC. (*Vide* TABLE I AND CHART NO. 5.)

Out of fifty-seven cases :

	No. of cases.
The affected child was first-born	8
.. .. second-born	14
.. .. third-born	15
.. .. fourth-born	9
.. .. fifth-born	5
.. .. sixth-born	5
.. .. seventh-born	1

That is, in over 50 per cent. of the cases the affected child was

* Erasmus Wilson (*Lectures on Eczema*), in a series of thirty-four cases, gives 22 males to 12 females, and suggests that the male preponderance is purely accidental; possibly it is so, but considering that there are as many, if not more, female than male births, the male preponderance is worth consideration. No question can here arise of extra exposure, different work, or food in the two sexes, such as may be raised in the case of adults.

† In compiling these figures the age is that of the mother *at the time the child was born*.

either second or third born; in 14 per cent. only was it first-born, leaving 86 per cent. in which the child was other than first-born.

Table 2 shows that, as a rule, eczematous infants are not children of very large families, nor is the average interval between the birth of the affected child, and of the preceding one, of short duration. This point is of some importance, as very frequent child-bearing not only tends to exhaust the mother, and thus possibly to affect her milk supply injuriously, but also it increases her domestic duties, and hence tends towards neglect in the care of the children. There is no evidence of either of these factors in these cases. (*Vide* also (l).)

II. EVIDENCE OF SKIN DISEASE IN MOTHERS. (TABLE II AND CHART 6).

It is not easy to classify these into distinct and clear groups, owing to the vagueness of the histories, and the absence of any exact definition of eczema. Many of the mothers, as will be seen from Table II, show distinct signs of what some would call seborrhoic eczema. Others, however, would decline to accept these various slight skin lesions as eczema, and would designate them seborrhœa, rosacea, pityriasis, etc.

For the purpose of this thesis I shall not consider these "stigmata" as "definite outbreaks of eczema."

I have divided the mothers into four classes:

(a) Those in whom there is evidence of "definite eczema outbreaks" at some time or other.

(b) Those in whom there is some present abnormal condition of skin, such as seborrhœa.

(c) Those in whom there is a vague history of some "skin disease" in the past.

(d) Those in whom there is neither history of past skin disease, nor evidence of present skin lesion of any kind.

Class A.—In seven out of fifty-four mothers from whom information was obtained—that is, in 12·9 per cent.—there is a history of definite eczema outbreaks. Of these two had it in infancy, three have had it in recent years, and the remaining two are suffering from it at present. Of the two who had it in infancy, the notes are as follows:

CASE 2.—"Mother had 'scald head' when a baby, cutting her teeth."

CASE 60.—“Mother had similar rash on face after vaccination, which lasted till she was twelve years. Had outbreaks on her knees towards the end.”

Possibly others also had it in infancy, and were never told of the fact, but I cannot think that is likely to happen often.

Of the remaining five cases the notes are as follows :

CASE 21.—“Has had papular eruption on face since childhood.”

CASE 34.—“Was under my care in hospital two years before with eczema.”

CASE 42.—“Just before becoming pregnant with this child had breaking out on face, all over, lasted one month; has now remains at backs of ears and back of neck.”

CASE 49.—“Mother has eczema of ears and eyelids.”

CASE 56.—“For last five years, off and on, rash on head, at back of neck, and down sides of cheeks, varies in severity, never quite gone from ears.”

Class B.—No history of any definite outbreak, but present evidence of slight skin affections. Of these there are seventeen (31·4 per cent.). The notes on each are as follows :

CASE 4.—“Scaly patches on nose and chin.”

.. 5.—“Dry scaly patches, cheeks, and sides of nose.”

.. 6.—“Dry scaly face.”

.. 8.—“Dry patches on nose, chin, and cheeks.”

.. 12.—“Dry skin of face.”

.. 20.—“Dry patches at hair roots, with few crusts; rosacea.”

.. 21.—“Face dry and scaly.”

.. 23.—“Dry scaly patches at corners of mouth.”

.. 27.—“Dry scaly face.”

.. 38.—“Dry face.”

.. 44.—“Right cheek dry and scaly.”

.. 45.—“Dry patches at corners of mouth.”

.. 46.—“Rough dry patch behind right ear.”

.. 47.—“Dry scurf about temples and neck.”

.. 57.—“Dry patches on cheek; rosacea.”

.. 58.—“Dry patches on cheeks, inflamed lids.”

.. 59.—“Dry scurfy face.”

The conditions common to most of the above are, localised, or, more or less diffuse, dry, finely scaling areas about the face, head, ears, or neck, such as one sees so frequently in children and adults, in these regions. If these are, as is suggested, stigmata of seborrhoic eczema, then these seventeen mothers are eczematous persons, who have never had any severe outbreak all their lives, but in whom the morococcus, or whatever organism may be the cause, has a footing. If so, they may be capable of directly infecting their offspring, and

the affected children should have seborrhoeic eczema like the parent. Whether they have or not we shall discuss later.

Class C.—No present evidence of any skin lesion. Vague history of past skin disease. Of these there are six (11 per cent.) of which the notes are as follows :

CASE 10.—	“ Bad hands a year ago.”
„ 14.—	“ Face scurfy in winter.”
„ 15.—	“ Bad ear when a child.”
„ 35.—	“ Scurfy face in summer.”
„ 39.—	“ “ “

And lastly, Case 29, “ Rash on face after vaccination ; ” but as I have no note as to whether this was in childhood or not, I cannot definitely classify it under infant eczema, so leave it here as vague.

Class D.—No evidence of any skin disease at any time. Of these there are twenty-four (44·5 per cent.).

We get, then, the following table in round numbers :

Mothers.		
CLASS A.—	Definite outbreak of eczema . . .	13 per cent.
„ B.—	Present slight evidence of seborrhœa . . .	31·5 per cent.
„ C.—	Vague history of skin disease.	11 per cent.
„ D.—	No past or present skin disease	44·5 per cent.
		<hr/> 100·0

(e) EVIDENCE OF SKIN DISEASE, PAST OR PRESENT, IN OTHER CHILDREN.
(*Vide* TABLE I AND CHART NO. 7.)

Out of the sixty cases, we can eliminate eight, in which the child affected was a firstborn, and two, in which no definite statement is made, so that there are fifty cases of which particulars were obtained.

In these fifty cases there have been born, exclusive of the patients affected, one hundred and twenty-three children (that is, an average total family of 3·5).

Of the 123 children :

There has been an outbreak of eczema in . . .	3 (2·43 per cent.)
„ „ some vague skin disease in . . .	9 (7·29 per cent.)
„ „ no skin disease at all in . . .	111 (90·28 per cent.)

When we look into the details, we find that of the three in whom an attack of eczema is recorded :

CASE 4.—“ Had a rash on head, starting two weeks after birth in July, 1895, mother having a bad head at the time.”

CHARTS 1 AND 2.

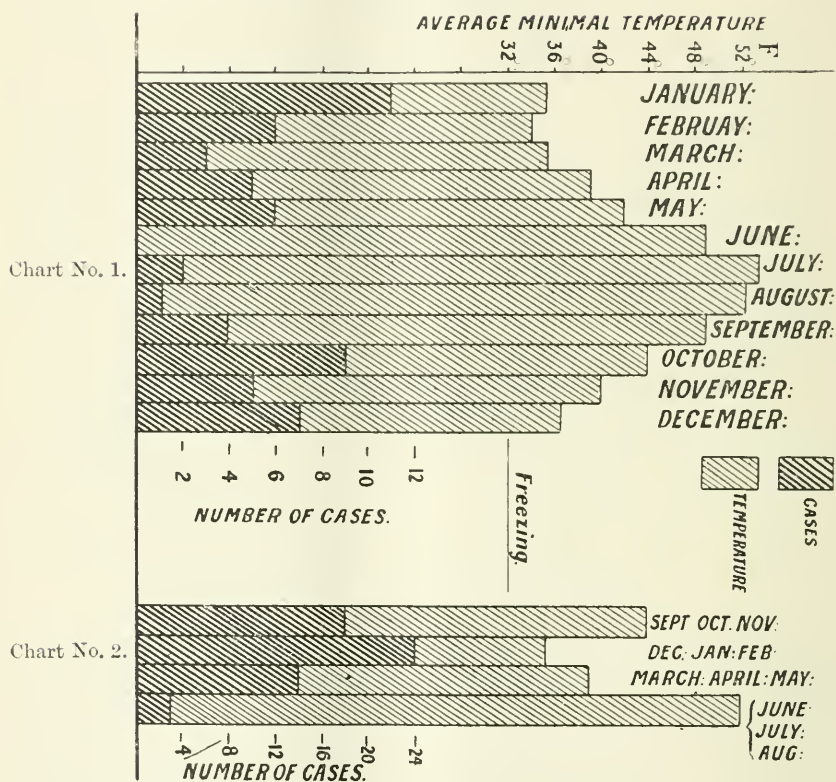
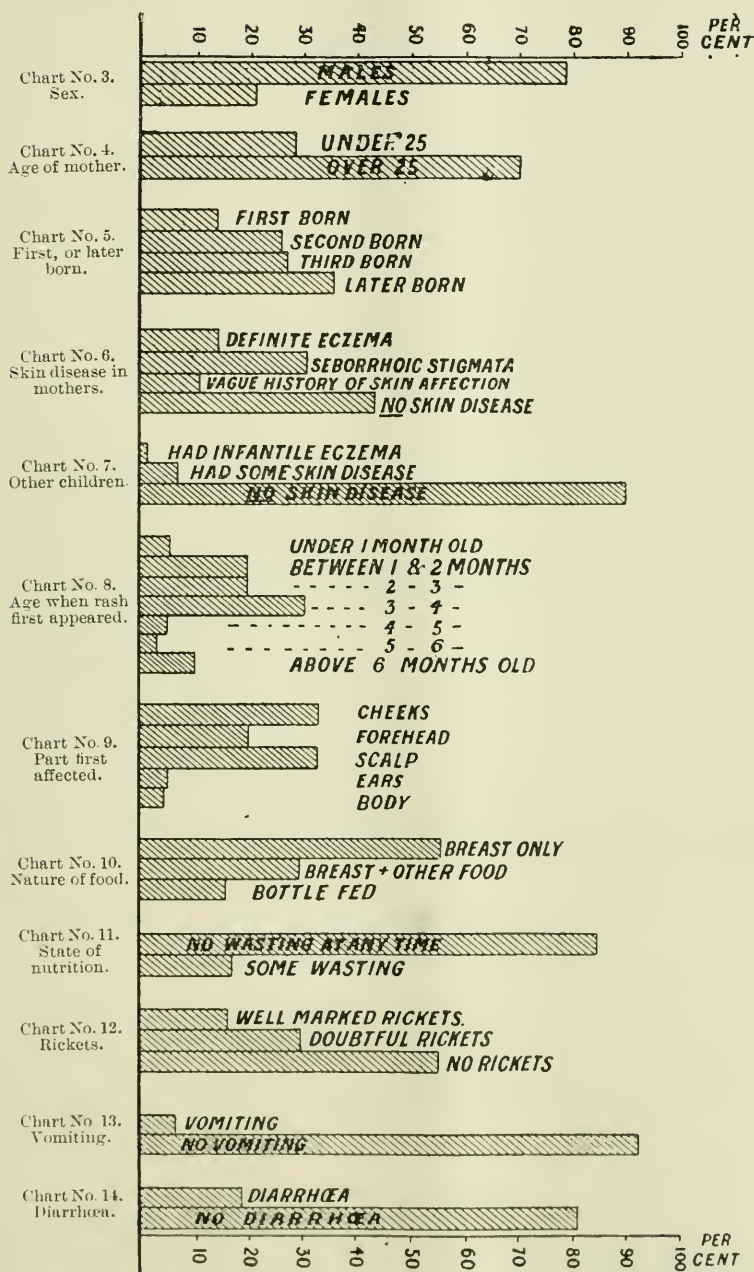


Chart No. 1.—Actual number of cases beginning in each month (shaded dark), with average minimal monthly temperature in Sheffield during the six years 1897 to 1902 (shaded light).

Chart No. 2.—The same arranged in periods of three months according to the seasons.

CHARTS 3 TO 14.



CASE 24.—"Little boy began like this at three weeks and it still remains."

CASE 59.—"Little boy has eczema now, since one year old."

These three seem to be fairly definite infantile eczema.

Of the nine cases where there is some vague history of skin disease there are the following records :

CASE 2.—"Younger baby has slight dry scaling of cheeks."

CASE 7.—"Eldest child (step-brother) had breaking out of head every year."

CASE 8.—"Brother had spots on his heels."

CASE 14.—"Twin has few spots on head."

CASE 26.—"Brother broke out on top of head two years ago, eyes sore, not well yet."

CASE 32.—"Step-brother had something very bad, left scars."

CASE 42.—"Second child has had spots on legs for last twelve months."

CASE 52.—"Elder child died; ? similar rash."

CASE 59.—"One child dry skin."

Of these, Nos. 8, 32, and 42 may be eliminated as probably not eczema. Cases 2 and 59 may be looked upon as seborrhœa, whilst the rest are possibly eczema.

Of Case 14 it is important to say a word: the affected child was one of twins, and the mother said the other twin had also spots on its head, but these were nothing more than the seborrhoic scales of early infancy.

Putting the most unfavourable construction on these cases, we have the astonishing fact that of the other children of these parents not more than seven out of one hundred and twenty-three (5·6 per cent.) born of the same mothers, and, in most cases, suckled by them, have had any outbreak of skin disease that is, even probably, eczema; whilst only three (possibly four)—2·43 per cent.—are said to have had infantile eczema.*

(f) AGE OF CHILD WHEN THE ERUPTION FIRST APPEARED.

(Vide Table III and Chart No. 8.)

In sixty cases the rash first appeared at the following ages :

Age of child.		No. of cases.	
Above 1 but	Under 1 month	.	4
	2 months	.	12
	3 "	.	12
	4 "	.	19
	5 "	.	4
	6 "	.	2
6 "	12 "	.	7
		78·3 per cent.	
		21·7 per cent.	

* McCall Anderson (*Diseases of the Skin*, 2nd edit., 1894, p. 132) says: "It may occur in several of the same family, but usually in only one."

Thus about three quarters of the cases began between the ages of one month and four months.

This point will be referred to again later in connection with dentition.

(g) SITUATION OF FIRST APPEARANCE OF ERUPTION.

(*Vide* Table IV and Chart No. 9.)

Site of first eruption.	No. of cases.
Cheeks, forehead or temples	32
Scalp or behind ears	25
Elsewhere	3
	<hr/> 60

Further details are as follows :

Cases.		
On right cheek : 11, 13, 20, 21, 33, 35, 45, 57	8	} 20
„ left cheek : 2, 3, 18, 25, 26, 29, 53, 54, 60	9	
„ both cheeks : 9, 24, 59	3	
„ forehead : 5, 17, 28, 30, 32, 37, 39, 41, 44, 49, 50, 62	12	12
„ vertex : 6, 7, 8, 10, 12, 22, 23, 27, 31, 36, 40, 42, 43, 46, 48, 51, 55	17	} 21
„ occiput : 4, 16, 34, 38	4	
„ right ear : 15	1	} 4
„ left ear : 14, 58	2	
„ both ears : 47	1	
„ Elsewhere : 1, 19, 56	3	3
	<hr/> 60	<hr/> 60

The large percentage (95 per cent.) of cases in which the eruption first appeared on some part of the face or head, is a very striking feature of infantile eczema.

(h) TIME OF YEAR IN WHICH THE ERUPTION FIRST APPEARED.

(*Vide* Tables VIII and IX and Charts 1 and 2.)

In fifty-nine cases the actual month of onset was very carefully ascertained ; in one case it was impossible to verify the accuracy of the record, and this case has therefore been omitted.

The accompanying chart (No. 1) shows more clearly than any verbal description, the variations in the incidence of these cases of infantile eczema during different seasons.

It will be seen from the chart that there is a very distinct drop in the number of cases occurring during the warmer months of the

year. In order to make this more clear, I have also placed alongside the number of cases of infantile eczema occurring in each month, a chart of the average minimal temperature in Sheffield for the years during which the cases occurred.*

It will be noticed that the largest number of cases in any single month occurs in January, the next largest in October, whilst no cases occurred in June. It will also be noticed that there were more cases in May, than in April. This is, at first sight, somewhat contrary to what one would expect from the previous statement, but it is easily explained. Of the six cases which occurred in this month, two occurred in May, 1902, and three in May, 1903. In both these years May was, for a considerable part of its time, exceptionally cold. In one of the 1902 cases there is a note that the rash first appeared on Whit Tuesday, which was a particularly cold wet day in the Sheffield district.†

Chart 2 shows the relation of incidence to temperature more distinctly. Here I have taken the year in quarters, according to the temperature. Thus, December, January, and February, represent the coldest quarter, June, July, and August, the warmest. In this chart we see very clearly the correspondence between the number of cases and the variations of temperature. It may be objected that there are fewer cases during March, April, and May, than during September, October, and November, although in the latter three months the average temperature is higher than in the former. But it must be remembered, that it is probably relative change of temperature which acts on the skin, as well as extremes of cold; hence the first cold season of autumn, the end of September or October, is fruitful in new cases, as is seen in Chart 1.

* These temperatures have been calculated from the very valuable records kept for the Sheffield Corporation by E. Howarth, Esq., Curator of the Weston Park Museum, to whom I am indebted for permission to make use of them.

† During the six years 1897 to 1903 inclusive, the mean air temperature (Greenwich) during the summer quarters was, in round numbers, as follows:

1897	1.5	per cent.	above	average.
1898	4.5	..	..	..
1899	5	..	..	..
1900	3	..	..	..
1901	2.8	..	..	..
1902	.5	..	..	below average.
1903	16.5	per cent.	below	average.

In confirmation of this statement I may add, that the four cases which occurred in infants under one month old, were all in cold months—namely, January, February, March and December; whilst those which appeared later than the common period of four months or under, of which there were twelve, were with two exceptions born in the warmer months—two in April, two in May, one in June, two in July, two in August, and one in September. The exceptions to this rule were one child, born in October, who did not begin till February; the other, born in February, began in the following October, but even these do not really oppose the view that relative cold is an important factor. As compared to October, February is the colder; whilst in the case of the child born in February, it may have been well protected in its early days of the spring quarter, then passed safely through the warmer months, only to acquire eczema in the first cold of October, the month in which so many of the cases began.

Again, as regards the four cases occurring in September, one of them (Case 1) began on the body, and probably its origin is different, whilst in the other three, it is expressly stated that it began in the last week of the month; in fact, one of them (Case 20) is uncertain as to whether it was not in October. Frequently, as for example during 1903, there is a short cold spell in late September. As regards the one case that occurred in August (Case 3) the infant was taken by train to Cleethorpes (on the East Coast) for the day, where the rash was first noticed. Whether this was due to the sun, or whether to a cold day, or to exposure in a railway carriage near the open window, I do not know. It occurred in 1898, and I find that in August of that year there was a particularly cold spell of weather from August 7th to 10th, the minimum temperature falling to 45.9° F., after having been ten degrees higher.

As regards the two cases which first appeared in July, one was in 1899, the other in 1903; as regards the latter, the rash appeared during the last week of the month, which, as a matter of fact, was particularly cold for the time of year.

It will thus be seen that the evidence points to cold seasons as playing an important part in determining the eczema outbreak in most of these sixty cases.

I wish particularly to call attention to the fact (which will be

referred to again) that those months (July, August, and September) in which all kinds of gastro-enteric affections are particularly prevalent in infants, are the very months in which the smallest percentage of my cases occurred. This is an important point in considering the supposed connection between digestive disturbances and infantile eczema.

I cannot refrain from referring to Erasmus Wilson (*loc. cit.*), who gives a very interesting account of a case. A lady took her suckling child a long journey (by train, or coach, I do not know), and in doing so, the mother was so exposed to severe weather that her milk began to fail, and the child immediately began with eczema. Wilson seems entirely to have overlooked the possibility, that the severe exposure of the mother meant, probably, more or less exposure of the child also; although he is one of the few who point out, that cold seasons play a part in this condition. (*Vide* Section 1, *supra*.)

(i) NATURE OF FOOD AT THE TIME WHEN RASH FIRST APPEARED.

(*Vide* Table III and Chart No. 10.)

Of the sixty cases there is a definite statement in fifty-nine.

Nature of food.	No. of cases.
Breast only	33
Breast and other things	18
Bottle-fed entirely	8
	86·6 per cent.
	13·5 per cent.

These data have been very carefully obtained, and I believe they are as accurate as is possible, when the answers have to be given by the uneducated.

As regards the food other than the breast given in the eighteen cases—

Nature of food.	No. of cases.
Patent foods	2
Crusts	4
Rusks or biscuits	7
Sago	1
Uncertain	4
Total	18

Thus, in 86·4 per cent. of the cases the child was solely or chiefly breast-fed, whilst only in 13·6 per cent. was it entirely artificially fed.

(j) THE RELATION OF VACCINATION TO INFANTILE ECZEMA.

(*Vide* Table V.)

Unfortunately, definite systematic inquiry on this point was not begun until Case No. 38, so that we may divide the cases into two divisions:—

Division A, cases 1-37, or thirty-seven cases. (No systematic inquiry.)

„ B, „ 38-60, or twenty-three „ (Systematic inquiry.)

In Division B definite information was obtained in nineteen cases.

The child was *not* vaccinated before the rash appeared in eleven.

The child *was* vaccinated before the rash appeared in eight.

In these eight cases the interval between vaccination and the appearance of the rash was as follows:—

Less than one month	2
Between one and two months	2
Three months or over	4
(In one case ten months.)	

In Division A, thirty-seven cases.

In six cases the vaccination date was given voluntarily (and ascribed as the cause), leaving thirty-one cases in which the parents never alluded to the subject. It is fair to consider that in all probability the children in most of these thirty-one cases had *not* been vaccinated before the rash appeared, otherwise it would certainly have been assumed as the cause, and we should have heard of it.

We have thus thirty-seven cases:—

	No. of cases.
No mention of vaccination	31
Vaccination before rash	6

In these six cases the intervals are as follows:

Less than a month	5
More than a month	1

Of the five above:

Case 30	“ Rash three days after vaccination.”
Cases 25 and 28	„ one week „ „
Cases 17 and 34	„ two weeks „ „

If these summaries be accepted, we should have sixty cases as follows:

	No.
Cases in which vaccination preceded rash	14
Cases in which rash preceded vaccination	46

If we allow three months as the outside limit of time for vaccination to cause eczema, we have only ten cases out of the sixty (16·6 per cent.) in which one might fairly describe the two events as *propter hoc* and not *post hoc*.

When one considers the comparatively close approximation between the ages at which vaccination is usually performed and infantile eczema commonly appears, such a percentage as 16·6 does not seem to me to warrant our assuming *in any case* that the vaccination causes the eczema.

(k) EVIDENCE AS TO DENTITION.

(*Vide* Table V.)

In fifty-six cases :

	No. of cases.
First dentition preceded rash	7
Rash preceded first dentition	49
	<hr/> 56

Of these forty-nine :

Interval between rash appearing and first dentition was less than 2 months	1
Interval between rash appearing and first dentition was greater than 2 months	37

In the remaining eleven no tooth had been cut when the child was first brought up, but the interval was then less than two months.

Of the seven cases in which first dentition preceded the eruption :

CASE 32.—“ Was born with two lower incisors cut and the rash did not appear till six weeks old.”

CASE 19.—“ Cut first tooth at five months and rash did not appear till two months later.”

CASE 15.—“ Cut first tooth at five months and rash did not appear till seven months later.”

CASE 1.—“ Cut first tooth at four months rash appeared one month later.”

CASE 8.—“ Rash and first tooth both appeared when six months old.”

CASE 56.—“ First tooth at seven months, rash four months later.”

It will, I think, be agreed that if a tooth has actually been cut for a month, the worst of the irritation likely to produce reflex nervous trouble is by then over ; also it is fair to assume that a tooth does

not begin to cause reflex trouble more than two months before it is actually cut; if, then, we add together all the cases in which the rash first appeared within these very wide margins, we get the following:

That in fifty-six cases:

	No. of cases.
The above conditions were complied with in . . .	3
„ „ „ not complied with in . . .	53
	<hr/> 56

In other words, in a little over 5 per cent. only, had dentition begun within the space of a month before, or two months after, the appearance of the rash.

Surely we may, once and for all, eliminate dentition as an ætiological factor in infantile eczema, and feel quite clear that when the two coincide it is a simple chance as regards their relationship to one another.

(I) EVIDENCE OF GASTRO-INTESTINAL DISTURBANCES.

(*Vide* Tables VI and VII, and Charts No. 11, 12, 13, and 14.)

In order to ascertain how far gastro-intestinal disturbances are a causative factor in infantile eczema inquiry was made as to any symptoms which might point to such disturbances. The word “disturbances” is used purposely; because, it is evident that various authors who refer to this point, not only differ from each other as to the particular character of the alimentary trouble, but, individually, attribute the disease to diametrically opposite conditions, as may be readily seen from the quotations in the historical sketch. We may suppose, for the sake of argument, either that (*a*) the food is insufficient in one or all its constituents, hence that the child does not receive sufficient food; or (*b*) that the food, though sufficient, is of a kind which does not agree, so that the child suffers from some form of infantile dyspepsia; or (*c*) that the food is too “rich,” and that the child is being overfed.

In considering these *seriatim*, what evidence do we get that the food is insufficient in one or more of its constituents? A food of the former kind must show itself in one way, and in one way only, namely, by the child not “getting on,” by its being deficient in size and weight.

Inquiry on this point was made in fifty-two cases (and I fancy in

the other eight cases the child was so obviously well nourished that the question seemed ridiculous, and was not asked in consequence).

Out of the fifty-two cases:

There was some malnutrition in	8 (15·3 per cent.)
None whatever at any time in	44 (84·7 per cent.)

These are the actual figures, but it must be remembered that frequently the child, when seen, had been suffering from the affection for weeks or months, and that the wasting had, quite as likely, occurred long after the disease appeared. This is quite sufficient to account for the 15 per cent. Apart from figures, however, anyone who has seen many such cases, knows that the sufferers are, usually, not in the least undeveloped or wasted, at any rate in the earlier stages. On the other hand, there are scores of wasted, starved children who come up to an out-patient department with never a trace of eczema.

Is it, then, that some one of the constituents of the food is deficient, or possibly more than one?

This question is more difficult to answer with certainty. If it were so, we should naturally expect the disease more often in hand-fed than in breast-fed children; but as we have seen above, in only 13·6 per cent. of them was there artificial feeding, the remaining 86·4 per cent. being breast-fed.

Again, the average age at which the eruption appears is so early, that the mother's milk is much less likely to be getting poor, and insufficient in any particular, than it might be, say, after a nine months' suckling; and I may say that in this district twelve to fifteen months is the common period for suckling to continue. Nor do my inquiries point to any great frequency of child-bearing in these cases, such as might be expected to cause a defective milk supply, through exhaustion of the mother; for I find, that in thirty-seven cases in which the period between the birth of the affected child and of the one which preceded it can be accurately reckoned, the results are as follows:—

Interval between birth of previous child and of affected child.	No. of cases.
Less than one year	0
One but less than two years	5
Two but less than three years	16
Three years or over	16
	<hr/> 37

Thus in 86·4 per cent. of cases there had been an interval of at least two years between the two children, and in 43·2 per cent., or nearly half the whole number, one of over three years. To those who know the average rate of child bearing in our populous cities this is not a high birth frequency.

Then, looking at the mothers themselves, although I have no definite statement, I am quite sure that they are usually well nourished and in good health. For although a certain number are somewhat run down from sleepless nights with a fretful baby, after the disease has lasted long, yet I do not remember a single case in which the mother of an eczematous baby has asked for treatment for herself on account of ill health. There are large numbers of worn-out suckling mothers who come to hospital, complaining of all sorts of aches and pains, dizziness, fainting bouts, etc., and who are terribly anæmic, so that one wonders how they can secrete any milk at all, and yet I do not remember, in a single such case, the child developing eczema. I am well aware that Nature's laws, especially as regards everything connected with reproduction, are so strongly in favour of the offspring, that she does not spare the mother in order to nourish the child, and possibly the exhausted anæmic mother is giving her all to provide what is really a perfect food supply, and is thereby suffering.

Lastly, the one disease which we believe to be caused by food being defective in certain constituents is Rickets. How far, then, are eczematous infants rachitic? It is obvious that in such cases the rickets and the eczema might be common results of the same causes, for it is hardly usual to find marked evidence of rickets at the age when eczema usually appears. In attempting to get information on this subject, I have found considerable difficulty in arriving at definite results, and I am convinced that my statistics as regards the presence of rickets would be modified in the direction of lessening the percentage, had I to examine the cases again.

Inquiry was directed to the following points: (1) Beading of ribs; (2) Enlargement of joints; (3) Sweating on head during sleep; (4) Prominence of belly.

Of these No. 3 is, obviously, in cases where the scalp is extensively covered with eczema, impossible to observe, and the answers are practically worthless.

But the greatest difficulty I have found is in estimating Nos. 1 and

2. The fat wrist of a young baby with the skin attached lightly close over the wrist itself, and the flesh bulging out above, often looks exceedingly like an enlarged lower end of the fore-arm bones, and, I am sure that, in my earlier cases, I have frequently mistaken it for such. Again, I am inclined to think that many babies have a very slight prominence at the junction of the ribs with the cartilages, which does not necessarily indicate rickets. In my desire not to minimise the presence of rickets, I am afraid I have marked these as beaded ribs. If, however, one looks at these statistics, and notes how many cases of well-marked rickets there are, one finds that out of fifty-one cases where the patients were examined—

There was evident rickets in	8 (15·6 per cent.)
„ certainly no rickets in	23 (54·9 per cent.)
Doubtful in	15 (29·5 per cent.)
	<hr/> 51

Of course it is possible to say that the fifteen doubtful ones were early cases, which probably became fully developed rickets later, but even then we have more than 54·9 per cent. of the cases examined showing *no signs whatever of rickets*, often at considerable periods after the appearance of the eczema, and about 85 per cent. in whom the signs were insufficient to point to certain rickets.

The next point is, whether the food was of unsuitable character, so as to disagree, and produce what I may call, “infantile dyspepsia.” So far as I can see this can only be diagnosed either by vomiting, flatulence, colic, or diarrhœa.

On these points, the answers, with one or two exceptions, have been absolutely negative.

Vomiting :	No. of cases.
Present	4 (7·5 per cent.)
Absent	49 (92·5 per cent.)
	<hr/> 53
Diarrhœa :	
Present	10 (18·1 per cent.)
Absent	45 (81·9 per cent.)
	<hr/> 55

In six of the cases it had been “very slight,” “only for a day or two,” etc.

These sixty children, in fact, have shown a quite remarkable exemption from gastro-intestinal trouble of this sort. And I would here refer again to the very striking fact that the months during which, in these cases, eczema occurs least frequently, are exactly the months when the incidence of gastro-intestinal derangement generally is the greatest. If irritation of the digestive tract as a cause had the importance usually assigned to it, one would expect a large increase of infantile eczema during the very months when, according to my limited statistics, the fewest cases occur.

In many cases constipation has been complained of; but that is, surely, evidence, not of intestinal irritation by improper food, but rather of sluggish reflex action of the lower lumbar centres.

The last of the food questions is the most hopeless to try and answer. Some authors say the child is being over-fed, hence it gets eczema. They do not define whether they mean that the child is receiving more into its alimentary tube than it can absorb, or, whether they mean it is absorbing more than it can build up into tissue. In the former case there would be sure to be gastro-intestinal symptoms before long—vomiting, abdominal pain, or diarrhœa—which, as we have seen, rarely occur. In the latter case, it seems impossible at present to obtain any definite proof; in adults it might be urates and gout; at any rate, it would be heaviness and drowsiness. The infant does not have gout, and I have never heard any complaints of thick high-coloured urine, whilst, in my experience, the eczematous baby is oftenest bright, happy, and lively.

If, however, we have no direct proof of this, which is a mere assertion, we have indirectly much against it; the children are breast-fed, not artificially fed; their mothers are usually wives of working men, amongst whom rich food is not much known, and except for the eczema they are frequently in particularly good health.

For me, the statement without further evidence does not carry conviction.

(To be continued.)

SOCIETY INTELLIGENCE.

THE DERMATOLOGICAL SOCIETY OF LONDON.

THE Annual General Meeting of this Society was held on Wednesday, May 10th, 1905, Dr. J. J. PRINGLE in the chair.

The following gentlemen were elected to serve as officers for the ensuing year :

Council.—H. G. Adamson, Willmott Evans, T. Colcott Fox, James Galloway, Malcolm Morris, J. A. Ormerod, J. J. Pringle, Edward Stainer, J. Herbert Stowers, Norman Walker.

Honorary Treasurer.—H. Radcliffe-Crocker.

Honorary Secretaries.—Arthur Whitfield, E. G. Graham Little.

The following cases were brought forward :

Dr. H. G. ADAMSON showed (from the clinic of Dr. Colcott Fox) :
(1) A case of *congenital Xanthoma multiplex*. The patient was a healthy male child, aged $2\frac{1}{2}$ years. The lesions, about twenty in number, were scattered irregularly over the trunk, while there were several also upon the face and neck and two or three upon the scalp. They consisted of firm hemispherical papules of a bright yellow colour. They varied in size from that of a pin's head to that of a split-pea or larger. Two or three of the lesions had a reddish tinge, showing yellow only on pressure. One on the neck had the appearance of a small vascular nœvus, but this also became yellow on pressure.* There were no lesions upon visible mucous membranes, on the eyelids, about the joints, or on the palms. They were not grouped or arranged in lines as in many reported cases. The lesions had been first noticed during the first two weeks after birth, but many more had appeared since that time, fresh ones even quite recently. There were no other cases in the family. The bright yellow colour of the nodules had at once suggested the diagnosis of xanthoma. Urticaria pigmentosa of the nodular type could be excluded on account of the absence of urticaria or of factitious urticaria and by the colour and shape of the lesions. The exhibitor hoped to obtain a lesion for microscopical examination.

* In this connection it is interesting to recall Köbner's case of "Xanthoma Multiplex developed from Vasculo-pigmented Nævi," *Vierteljahrsschrift f. Derm. u. Syph.*, 1888, p. 393.—H. G. A.

(2) A case of *multiple Lupus following measles*. The patient was a healthy-looking boy, aged 5 years. There were about a dozen split-pea to sixpenny-piece sized lesions. There were two on the face, one on the little finger of the right hand, one on the back, two on the right thigh, and five or six upon the left knee. The larger lesions on the left knee and that on the right little finger were covered with scaly crusts; those on the face and some of the smaller lesions presented typical "apple-jelly" nodules. The lesions had been first noticed more than two years ago as small red "pimples," and they had gradually increased in size. The child had had measles two and a half years ago. There were no other evidences of tuberculosis.

Dr. COLCOTT FOX presented a woman, suffering from *epidermolysis*, whom he had previously exhibited to the Society. He had demonstrated the case at the International Congress of Dermatology and Syphilis, in 1896, and published the case in the *British Journal of Dermatology*, vol. ix, No. 107, with the title, "*Pemphigus in a woman, of nine years' duration, at first indistinguishable from ordinary pemphigus; afterwards with all the clinical characteristics of pemphigus congenitalis (epidermolysis); epidermic cysts; essential shrinking of the conjunctiva.*" On May 10th, 1905, the case was typical of epidermolysis with progressive deformations. The essential shrinking of the conjunctivæ was increasing. The tongue was contracted and its surface and attachments cicatricial. The lips were superficially ulcerated and in part cicatricial. She could not eat a crust without producing phlyctenæ. Over bony prominences of the limbs phlyctenæ arose, leaving exulcerations, and also beneath the corsets. The nails had disappeared, leaving the nail-beds cicatricial. At one time there was a great deal of milium, but that had gone. The skin, especially of the limbs, was becoming atrophic, *i. e.* dry, thin, like tissue-paper, and marked out in lozenge-shaped areas as in ichthyosis. The special feature of the case was that some twelve years ago the affection commenced by what was apparently severe generalised Pemphigus vulgaris. Prior to that the skin was quite sound. The exhibitor saw her in the first attacks. The spontaneous formation of bullæ had ceased for some years. Dr. Fox called special attention to the atrophy, which was exactly comparable to that of the woman (Elizabeth B—) who was known to most of the members of the Society as suffering

from congenital epidermolysis. He suggested that this atrophy was not secondary to repeated phlyctenæ, but an essential outcome of the disease process. He also called attention to the copious papular keratoma of the palms and soles, which was observed sometimes in pemphigus, and was a striking feature of the case of Pemphigus vegetans lately recorded by Sir Dyce Duckworth. In the latter case it was certainly not due to arsenic. In the woman now exhibited it had gradually set in, although she has not taken arsenic for some years.

Dr. S. E. DORE showed *a case for diagnosis*, seen by him at the Middlesex Hospital in Dr. Pringle's absence. The patient was a man, aged 60 years, and was employed as a labourer in the Weights and Measures Department of the London County Council.

In addition to a chronic dermatitis of 12 months' duration, affecting his hands, fingers, and nails, he presented a peculiar eruption, which he had first noticed 10 years ago, on both his forearms, extending from the wrist to just below the elbow. The latter eruption appeared to be made up of small telangiectatic points and small areas of pigmentation, alternating with pale areas of healthy skin, the combination producing a mottled and somewhat retiform appearance. No atrophy or scarring could be detected, and there were no subjective symptoms. According to the patient's account the condition had spread during the first five years, and for five years had remained stationary. There had been no recent exposure to sun or heat, and he worked with his arms covered; in previous years, however, he had been a farmer. The telangiectases and pigmentation suggested the condition sometimes brought about by long exposure to X-rays.

No diagnosis was offered. Dr. PRINGLE said he had seen similar cases and considered them to be of the "infective" angioma type.

Dr. J. M. H. MACLEOD showed *a case for diagnosis*. The patient was a clerk, aged 65 years, of medium height and spare build, who presented himself for treatment at Charing Cross Hospital in March, 1905, suffering from granulomatous masses situated in the front and sides of the neck, and in the left axilla. The lesions in the neck were broken up by deep transverse furrows, presented several sinuses discharging a yellowish sero-purulent fluid, and the skin over them

was reddish purple in colour and œdematous. The history of the case was indefinite. The disease began in 1902 with a swelling on the right side of the neck, which the patient believed to be a swollen gland; there was also a small swelling on the right side of the abdomen associated with pain, on account of which he became an in-patient at the Homœopathic Hospital in Great Ormond Street. While there the abdominal lesion gradually disappeared, but the swellings on his neck increased, and others appeared on the left side. Since then the skin lesions had continued, new ones appearing on the front of the chest and in the left axilla. In the right axilla a swollen gland was present. Since he came under observation at Charing Cross Hospital he had been treated with 10-grain doses of iodide of potassium three times a day, and there had been an appreciable flattening of the lesions in the neck, and a diminution in the discharge. A bacteriological examination was made on two occasions, but so far with negative results, and unfortunately, permission to make a biopsy was not obtained. At first sight the lesions suggested those of actinomycosis, but the history and the duration were against this diagnosis. Another possibility, and one which seemed more probable, was that it was a streptothrix infection, due to some other fungus than to *S. actinomycetica*. The exhibitor hoped to report further on the case.

Dr. J. J. PRINGLE considered that the condition was more suggestive of streptothrix invasion than of breaking-down gummata, which had also been suggested as a possible diagnosis.

Dr. SEQUEIRA showed a girl, aged 15 years, suffering from *verruca juveniles*. The interest in the case lay in the wide distribution of the warts, which were scattered over the hands, wrists, and forearms and the cheeks and forehead.

Mr. GERALD SICHEL showed the following two cases from Sir Cooper Perry's out-patients:

(1) A case of *Sarcomatosis cutis* in an old man, aged 71 years, who had attended for multiple swellings of the skin, swollen lymphatic glands, and itching. Family history, negative. Personal history: He had served in the army in India. Present disease began six weeks ago with bullæ in both wrists and soles; these burst, and lumps appeared on various parts of the body. The patient was a strong, healthy-looking old man. He was suffering from a nodular eruption,

the smaller nodules being about the size of a split-pea, cutaneous or subcutaneous in position, and, except for the greater part of the trunk, practically universal and symmetrical in distribution. These small nodules were of the same colour as the normal skin. They were last seen and felt in the lower extremities, where the great itching had led to their being scratched, so that many were crowned with a speck of blood. On the face, neck, shoulders, in front of the bends of the elbows, and at the back of both knees, the nodules had run together or enlarged to form dusky-red, raised, brawny areas, with usually well-defined borders, and of varying size. The face was practically covered with such a patch, and the upper well-defined border fairly well corresponded to where the pressure of his hat would come. The scalp itself presented a speckled appearance from numerous minute red spots, which were not raised above the surrounding skin. The patches on the shoulders were most marked on the right side, where there were two well-defined tumours about the size of a florin and half-a-crown respectively. The axillary, inguinal, and left epitrochlear glands were enlarged. The scrotum and penis were covered with red patches. The skin of the palmar surfaces of hands and wrists was rough and scaly, especially over the thenar eminences. The left hand was very oedematous. The patient himself was drowsy, rapidly and constantly falling asleep if undisturbed. The possibility of Mycosis fungoides was discussed, but the general opinion was that the diagnosis of Sarcomatosis cutis was correct.

(2) A case of *Erythema iris* on the hands of a woman, aged 37 years. The attack had commenced with a herpes-like eruption on the mucous membrane of the mouth a week previously. The patient had never had rheumatism, but thought she had had a previous attack of the present eruption.

Dr. F. PARKES WEBER showed a case of unusual *cutaneous pigmentation* in a girl, aged 14 years, possibly *allied to Recklinghausen's disease*—that is to say, a case of neurofibromatosis, with cutaneous pigmentation, but as yet practically without any (superficial) tumours. The pigmentation chiefly affected the trunk and neck, the extremities being much less affected and the face almost free. There were no areas of leucodermia. There was no evidence of urticaria, factitious urticaria, purpura, or any kind of erythema in connection with the

condition. The pigmentation was, roughly speaking, of three kinds—(1) diffuse brownish patches, especially a large patch over the upper part of the back and neck, which had a sharply-defined, probably stationary, upper border, but was ill defined below (in which direction it seemed to be spreading), and merged gradually into the ordinary skin; (2) brown spots and small patches, plentifully scattered over the trunk, the paler ones apparently being those most recently developed. (3) A group of very dark, almost black, spots, on the left side of the thorax, resembling a group of “pigment-naevi,” but not raised above the general level of the skin. These blackish spots had been noticed about three years ago. The earliest pigmentation noticed by the mother was at the back of the neck when the child was only about 18 months old. Since that time the rest of the pigmentation had gradually developed, and fresh (faint) spots and patches had appeared recently on the extremities. Menstruation had not yet commenced. The patient’s general nutrition was fairly good. Though she looked rather pale, examination of the blood (Dr. Schenck) showed nothing of pathological significance. The arterial blood-pressure in each arm was found to be equal (about 130 mm. of mercury) by the Riva-Rocci instrument. Examination of the thoracic and abdominal viscera and of the urine showed nothing abnormal. The cutaneous sensation, knee-jerks and plantar reflexes, were natural. The mental development and the general intelligence were quite up to the average. There was no pigmentation in the mucous membrane of the mouth. In the past history of the patient the only noteworthy point was that she had always been very liable to headache and attacks of bilious vomiting. But there had been no tendency to fainting to suggest Addison’s disease. On the contrary, the attacks of vomiting seemed to be induced by certain articles of food (rich fatty things, and at one time raw apples), and the patient’s mother had likewise as a child and young woman been subject to so-called “bilious attacks.” One or two others in the family were inclined to similar attacks. Apparently no anomalous cutaneous pigmentation had been observed amongst the relations. In the present case it was to be noted that the pigmentation affected chiefly the covered parts of the body, and that there was no special liability to freckling from exposure to the sun. This was the reverse of what occurred in Xerodermia pigmentosa. The pigmentation was more probably allied

to Recklinghausen's disease, as Dr. Whitfield had suggested when he heard of the case. In support of this theory there was the presence of a single small, flaccid, fibroma molluscum on the lower part of the patient's back, which was first noticed about three years ago. It should be mentioned for the sake of exactness that the patient had recently been treated with arsenic.

THE DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.

A MEETING of this Society was held on Wednesday, April 26th, 1905, Dr. H. WALDO in the chair.

The following cases were exhibited :

Mr. T. J. P. HARTIGAN showed :

(1) A man with an *ulcer on the lip* of seven years' duration. There were no enlarged glands, and it was unaccompanied by pain. The condition was thought at first to be a rodent ulcer, but microscopic examination proved it to be of an epitheliomatous nature. It had improved after three exposures to radium.

(2) A case of *early Mycosis fungoides* which had been practically cured by the X-rays.

Mr. GEORGE PERNET suggested the possibility of the case having been of the nature of an hypertrophic lichen planus, especially as the disease was limited to the lower extremities. It was very difficult to confirm or disprove the so-called "pre-mycotic" stage.

(3) A man in whom a *verrucose condition of the legs* had existed for about five years. In the opinion of the exhibitor this case also was one of *Mycosis fungoides*.

Members dissented from this view and considered that this case was likewise one of *Lichen planus*.

(4) A girl, aged 14 years, with *Lichen spinulosus*, affecting chiefly the flexures of the joints. The condition had been present for two months.

Mr. GEORGE PERNET showed a case of *koilonychia*, occurring in a private patient, aged 49 years. Her nails had commenced to be

affected about three years previously, the change involving the nails of the index and middle fingers of both hands. These were more or less spoon-shaped, and they presented transverse and longitudinal ribbing. Some keratosis of the nail-bed was observed about one of them. The nail of the right ring finger showed some undermining about the centre of its distal end. All the nails were finely ridged longitudinally. The patient had suffered from eczema of other parts for some few years, but the four altered nails did not appear to be the result of local skin changes (eczema) of the finger-ends. Her general health was good, and she was not anæmic. The teeth were fairly good, but the gums had begun to recede for about four years, in which period the hair had also become white, and some denudation at the frontal border of the scalp had occurred. The urine contained neither albumen nor sugar. The changes in the nails would, therefore, seem to be dependent upon some general condition.

The PRESIDENT thought that the condition was not uncommon among anæmic individuals.

Mr. HARTIGAN stated that he had seen several cases associated with eczema, and he thought that if the nails of patients were examined more systematically the condition would be even more commonly observed.

Dr. NORMAN MEACHEN had met with two cases occurring in two sisters, one of whom was convalescent from typhoid fever.

Dr. STOWERS considered that koilonychia was generally due to some disturbance of nutrition, rather than any local disorder. He called attention to the recession of the patient's gums, a symptom which he had previously observed in association with this particular deformity of the nails, especially during middle life.

Dr. V. H. RUTHERFORD showed the patient with *rodent ulcer* that he had exhibited at the previous meeting of the Society, in order to demonstrate the improvement which had resulted from systematic exposure to the X-rays.

Dr. T. D. SAVILL showed (1) a case of *tuberculosis cutis* in a woman, aged 80 years, sent to him by Dr. W. A. Collier, of Westminster. Four years ago her daughter died of phthisis, and the patient had nursed her throughout the illness. Soon after a small sore place was noticed upon the back of the left hand. In this region was now a large infiltrated patch, the surface of which was red and elevated above the surrounding skin, while here and there could be seen several adherent scabs. In the opinion of the exhibitor this was a case of definite

seuile tuberculosis in which there was a pretty clear history of contagion. It corresponded, therefore, somewhat to certain cases of verruca necrogenica. The condition had improved after repeated applications of pure phenol.

Other cases illustrating the theory of contagion were recalled by some of the members, while various suggestions were made as to the treatment of this case.

(2) A man, aged 27 years, with an *urticarial eruption accompanied by bullæ*, whom he had first seen on March 29th. The rash had then been present forty-eight hours, then appearing in the form of urticarial wheals and patches, some of which presented a bullous character, distributed nearly all over the body. For the last three years the patient had suffered from similar attacks, recurring about three times a year. On one occasion he was so ill with it that he went to Guy's Hospital as an in-patient. He was engaged in the printing of tin-plates. There was no history of venereal disease, no error in diet, neither had he been taking drugs. The present condition, one month after the sudden onset of the eruption, consisted of numerous symmetrical, pigmented patches upon the gluteal folds, the fronts of the knees, the forearms, and the dorsal surfaces of the feet. The palms showed some desquamation. When he was first seen the rash appeared clinically more like an *urticaria bullosa* than anything else.

Mr. PERNET said it reminded him somewhat of an antipyrin rash, but upon the whole he thought that it might be classed under the *erythema multiforme* group of skin affections.

Dr. J. H. STOWERS showed a case of *multiple erythematous lupus*, which he had previously exhibited before the Society (October, 1904), in order to demonstrate the great improvement which had resulted from the internal administration of quinine. The treatment was commenced in the early part of November, the patient taking five grains of the drug three times a day, no intolerance being shown. Very slight local treatment had been adopted. The disease had now almost completely cleared up, this good result being attributed by the exhibitor chiefly, if not wholly, to the effect of the quinine.

Other members recalled cases of *lupus erythematosus* which had been markedly benefited by this method of treatment.

CURRENT LITERATURE.

MERCURIAL INJECTIONS. LOUIS JULLIEN. (*Journ. des Mal. Cut. et Syph.*, December, 1904, vol. xvi, No. 12.)

Dr. JULLIEN contrasts the therapeutic exactitude of present-day methods of mercurial injection with the imprecision of the treatment by pills and solutions by the mouth, now rightly considered antiquated. But even greater exactitude and further simplification of the intra-muscular method will be acquired when it is generally realised that the factor of chief importance in the dosage is the actual weight of mercury introduced: it is of little use to compare results obtained from different preparations without recognising that they may contain very different proportions of mercury. Jullien strongly advocates the method which he has himself adopted of adjusting the dose of the particular preparation used to correspond to a fixed weight of mercury. He gives a table of the proportions of mercury in various salts and the dose of each which corresponds to 1 centigram of mercury. For example, the dose of salicylate of mercury necessary for an injection of 1 cgm. of mercury is 2.4 cgms.; while the dose of cyanide of mercury for 1 cgm. of mercury is 1.3 cgms. only. He finds that the various salts differ little from one another in their therapeutic effect, when each dose given has an equivalent of 1 cgm. of mercury.

The writer makes some observations also in respect of the insoluble preparations. Of *calomel* injections he says that it is the best treatment to institute upon the first appearance of the primary sore and often checks the disease permanently; that it is the method to be used in chronic manifestations, either grave or slight, but rebellious to other mercurial treatment; that above all, on account of its energetic and rapid action, it is the treatment for lesions which threaten delicate organs or higher structures which rapidly become disorganised.

From *calomel* to *grey-oil* is a long step. The latter method is relatively mild. The slight reaction which it provokes in the tissues or in the organism and the surety of its effects render it admirably suitable for the treatment of cases of mediate severity—the majority of cases. It is a simplified treatment for all, for patient and doctor; the several short series of weekly painless pricks employed with method and with moderation on subjects previously examined, of regular nutrition, with normal urinary function and whose teeth have been supervised, are found to be efficacious and inoffensive.

Jullien is accustomed to inject a dose corresponding to 5 cgm. of the metal each week (rather less than 1 grain) in series of 4-6 injections according to the condition of the patient and the nature of the lesions. In cases of urgency the intervals may be shortened or the doses increased to 7 cgms. It is essential to know exactly what one is doing and how far to go, and not to be tempted to exceed the ordinary doses without weighty reasons. The imprudent risk serious accidents, for which they alone are responsible. No comparison can be drawn between injections either soluble or, above all, insoluble, and pills which had to be continued more or less indefinitely with the accompaniment of obligatory stomatitis. But the modern arms of precision must not be used without due precautions. "Better a hundred times to hold to the old methods than to

approach, without an education and a rigid discipline, the practices which have assured the imperishable renown of Scarenzia and of Lang."

H. G. A.

NOTES AND REFLECTIONS WITH RESPECT TO A NEW CASE OF DARIER'S DISEASE. CH. AUDREY and E. DALOÛS. (*Journ. des Mal. Cut. et Syph.*, Tome xvi, No. 11, November, 1904, p. 801.)

THE case was a typical example of this affection in a woman, aged 44 years, of small intelligence and without education. The eruption had been present more than a dozen years; it began apparently upon the hands and forearms. Characteristic brownish, warty-looking lesions were present abundantly on the cheeks and neck, more sparsely on the face, on the back between the scapulae and again at the lower part, on the central part of the chest and above the right breast, in the axillae, on the posterior surface of the forearms. In these areas they were mostly grouped together into a single large patch, and individual lesions sometimes united to form little scaly or crusted placards. Some lesions were suppurating. The hands and fingers on their dorsal aspects presented the appearance of coarse shagreen, and the skin of the palms was thickened. On the feet were tiny elevations like flat warts. The nails were striated longitudinally, dry and thickened at the free ends. The scalp was covered with yellow crusts like tinea amiantacea, with here and there circumscribed patches of blackened crust. There was a horny condition of some of the papillae of the tongue. There was no itching. There was no visceral trouble. The blood was examined and found to be normal. Examination of the urine showed a sensible diminution of sulphur. A detailed account is given of the very careful and complete histological examination of the case. The usual appearances, as described by other observers, were found. The authors, however, draw special attention to certain points. Their examination showed that the process is primarily a simple hyperkeratosis, without either acanthosis, or acantholysis, or dermo-papillary reaction; the degenerative phenomena involving the follicles, or apparently follicular, are ultimate phenomena. These facts would seem to support the opinion of Campana, and others, that the disease is related to ichthyosis; but the resemblance is merely anatomical, and there is no true relationship. In a group of typical papular lesions removed from the arm, the follicular appearance was found to be due to umbilication, but no true follicular lesions were seen; some were centred by a hair, but the papules were alongside the follicle without involving it. The picture characteristic of the lesions of Darier's disease was found in sections of the verrucose skin of the hands, the lesion here being extended in a sheet instead of forming papules; both "grains" and "round bodies" could be here distinguished. The fissuring of the prickle-cell layers is, as others have asserted, to a certain extent artificial, or rather it is much exaggerated by fixation in alcohol. Fixation in alcohol is not therefore condemned; it is, on the contrary, necessary for a complete examination. The "round bodies" of Darier, though not to be regarded as specific, since they occur in other affections, are yet seen here in such numbers and with an arrangement which is distinctive. There is no reason to believe that the affection is of parasitic origin. Attention is called to the urine examination and to the diminution in the amount of sulphur, from which, however, no conclusions can be drawn without confirmation in other cases. The low intelligence of the

patient is noted; Darier attached importance to this, and it has been observed in a certain number of cases.

The authors regard the disease as an expression of dystrophy of the whole epidermis, a congenital force latent until some favourable but quite unknown conditions arise to set it free.

H. G. A.

SOME CUTANEOUS MANIFESTATIONS WHICH MAY ACCOMPANY CHRONIC APPENDICITIS. H. FOURNIER. (*Journ. des Mal. Cut. et Syph.*, December, 1904). Tome xvi, No. 12, p. 893.

FOURNIER draws attention to the great prevalence of chronic appendicitis at the present time—much greater than is commonly recognised. Chronic appendicitis is often concealed behind dyspepsia, enteritis, liver troubles, lithiasis. That it is of more frequent occurrence now than formerly is probably due to the increased consumption of meat foods, together with the comparative disuse of purgatives. Many authorities are quoted to show that appendicitis is in the majority of cases secondary to an entero-colitis. The entero-colitis is no doubt set up by excessive meat diet, the toxins resulting from which lead to spasm of the intestine and to chronic obstinate constipation favouring the development of a local infectious condition. This form of chronic entero-colitis, with frequent though usually not violent, outbursts of appendicitis, is very much more common than the generally recognised acute type of appendicitis. Fournier has observed in connection with such cases (several of which are here recorded) various skin eruptions which, recurring or aggravated with each outburst of abdominal symptoms, resisted all treatment locally, or by drugs, and only disappeared when the patients were put on a strictly vegetarian diet. In one instance the eruption ceased to appear after the patient underwent the operation for removal of the appendix. The eruptions included purpuras, prurigo, pruritus ani, and eczema of the lips, pruriginous acne, urticaria. The interest of the cases lies in the fact that in one instance the eruption led to the discovery of a hitherto unsuspected appendicitis and that in the other cases they confirmed for the author the existence of a lesion, without which they certainly would not have persisted or recurred as they did.

H. G. A.

A NEW FORM OF DERMATITIS (PAPULO-EXUDATIVE) CAUSED BY PILOCARPINE. HALLOPEAU and VIELLIARD. (*Ann. de Derm. et de Syph.*, March, 1904, p. 233.)

A PATIENT who was suspected to be suffering from early glaucoma, and had been treated with thirty-five hypodermic injections of pilocarpine and about eighty applications of drops containing eserine to the eye, was admitted to St. Louis Hospital with an eruption of papules on the face especially but also on the limbs. The papules were isolated in some parts, in others grouped; they were acuminate, with a central umbilication and an exudate, at first clear, later purulent; they were situated about the sweat-glands, as was demonstrated by sections taken of the papules; these showed a marked infiltration of leucocytes round the tubules of the sweat-glands. No micro-organisms were found. The patient died with symptoms of pilocarpine poisoning, and the manner in which the sweat-glands were apparently selectively affected confirmed the authors in the opinion that the eruption was due to pilocarpine.

E. G. L.

A CONTRIBUTION TO THE CLINICAL AND HISTOLOGICAL STUDY OF THE CUTANEOUS MANIFESTATIONS OF LEUKÆMIA AND PSEUDOLEUKÆMIA. NICOLAU. (*Ann. de Derm. et de Syph.*, August-September, 1904, p. 753.)

THE skin manifestations in leukemia and pseudoleukemia are of two kinds, and consist in the development of definite tumours on the skin, or in pruriginous, urticarial, or eczematous conditions. It is to the latter group that especial attention is to be directed, since it is probable that as more care is taken in the examination of the blood in dermatoses, many cases now classed with other diseases will enter this category. One case of each type here mentioned is analysed by the author. An attempt at a complete recital of previous cases of tumour-formation in leukemia precedes the consideration of the first case, which is of this type. The patient was a man aged 50 years, who had been the subject of the disease for five years, in the form of an ulcerating nodule in the cheek, accompanied by a general enlargement of glands, and of the spleen and tonsils. The proportion of white to red corpuscles was 1:97 of the white cells, of which 75 per cent. were lymphocytes and 24 per cent. polynuclear neutrophiles; hæmoglobin was 75 per cent. This was the condition noted in 1900. His ulcer partially healed under treatment with arsenic. He appeared ten months later with pulmonary complications which had been absent earlier. The glands had not enlarged appreciably beyond the degree noted, but the lymphocytosis had increased, the examination in July, 1901, showing 93 per cent. lymphocytes, with only 4.5 polynuclears. The lesion on the cheek remained nearly as before; but a new plaque of the same type on the forehead, and several nodules on the scalp, were now noted, together with a diffuse infiltration of the left external ear. He was seen again nine months later, under much the same conditions, and he died, not under observation, three years after the beginning of the disease, no post-mortem examination being made. Sections from the borders of the ulcer on the cheek and from the tumefied lobule on the ear were obtained, and a very detailed histological report is submitted. The opinion of their leukæmic character is confirmed by Jadassohn, in whose laboratory this research was conducted. The source of these cellular infiltrations is discussed, the contending views (1) that they are true lymphocytes derived from the lymph-making organs, (2) that they are derived from connective-tissue cells *in situ*, being impartially stated, the author adopting the view that they are derived from the lymph, and are true lymphocytes. The second case was a pseudoleukemia with a generalised erythrodermic exfoliation without skin-tumours and occurred in a man aged 60 years. There was general redness and exfoliation in dry scales, a moderate degree of itching, with no retraction or atrophy of the skin; the glands generally and the spleen were enlarged, and there was a relative increase in the percentage of lymphocytes in the blood. The patient died of purulent bronchitis two years after the commencement of the cutaneous affection. A general autopsy established the existence of lymphatic nodules on the surface of the lungs, enlargement of the tonsils and lymphatic follicles at the base of the tongue: the liver was diminished in size, with lymphatic nodules on its surface. The spleen was large, red, with hypertrophied follicles, and with enlarged lymphatic glands in the hilum; the mesenteric and retroperitoneal glands were much enlarged. The histological examination of the skin showed an infiltrate, chiefly around the vessels, of cells of two types: (1) A small round

cell of the form of a lymphocyte, and (2) cells like connective-tissue cells. There were no plasma-cells, but very numerous mast-cells. There were numerous pigment-cells in the lower part of the infiltration and scattered in the infiltrated areas of the papillary zone. Of these the larger cells gave reactions of melanin, the smaller ones of hæmosiderin. Round the sweat-coils also there were similar infiltrations of round cells, with many mast-cells.

It is obvious that the cutaneous symptoms approximate this case to the group of Hebra's Pityriasis rubra. A review of the literature is given, in which some cases of Pityriasis rubra associated with leukæmia are quoted. In Nicolau's case the absence of atrophy of the skin, which was such a cardinal feature in Hebra's description, differentiates it from the latter. The fact that several cases of Pityriasis rubra have been shown to be associated with tuberculosis—a fact much insisted on by Jadassohn, and confirmed in one recorded case at least by the demonstration of tubercle bacilli in the skin—lends colour to the assumption that if, as is probable, in these cases the so-called Pityriasis rubra constitutes an exanthem of tuberculosis, the similar eruption in pseudolenkæmia and leukæmia may in the same way be regarded as an associated exanthem. The subject can be elucidated only by a rigorous application to all cases of the disease clinically presenting itself as Pityriasis rubra of methods of examination involving the investigation of the histology of the skin lesions, the reaction to tuberculin, and the result in susceptible animals of the inoculation of the morbid tissue, and, above all, a complete inquiry by modern methods into the condition of the blood.

This paper, forty pages in length, is packed with matter for reflection. A full bibliography is given, and four chromolithographs illustrate the histological aspects.

E. G. L.

RHINOPHYMA — A PATHOLOGICAL ANALYSIS OF FIVE SEPARATE TUMOURS OCCURRING IN THE SAME PATIENT.

GROVER W. WENDE and CHARLES A. BENTZ. (*Journ. Cut. Dis., including Syph.*, October, 1904.)

THE man whose case was reported in the *Buffalo Medical Journal* died in 1902 of cirrhosis of the liver, and possibly cancer of the stomach. The five tumours, ranging in age from about twenty-five years to six months, were removed after death, and subjected to various fixing agents. The authors, after analysing the results obtained by others, summarise the changes found as follows. All observers agree that the anatomical structure consists of dilated blood-vessels, leading to the new formation of connective tissue and hypertrophy of the sebaceous glands. The authors also found dilated blood-vessels, varicosities, and thickening, and believed that they detected a new formation of blood-vessels. This state of the vessels governs the incipient stages. Increased cornification of the epidermis might be due to increased nutrition or the bacillus found (? acne bacillus). The abundant proliferation of epithelium might be accounted for by the increased nutrition or the secondary inflammatory phenomena. There was no numerical increase of sebaceous glands, only increased volume with dilated and even cystic excretory passages, and possibly the micro-organism found might partly account for this. The fibrous tissue was extremely hypertrophied and

denser, especially near the sebaceous glands. In many places it was of cicatricial consistency. The gland secretion was retained by the hypertrophy of the epithelium of the sebaceous ducts and the round-cell infiltration. Mast cells were increased in number, but nothing like to the same extent as other connective-tissue cells. No eosinophiles were discovered. Plasma cells were of the large variety. Many irregular pigmented cells were found, probably migratory.

T. C. F.

XANTHOMA MULTIPLEX: HISTOLOGY OF THE PALMAR STRIÆ. HENRY W. WHITEHOUSE. (*Journ. Cut. Dis., including Syph.*, October, 1904.)

IN a case of Xanthoma multiplex, unassociated with jaundice or diabetes, Dr. James C. Johnston reported on the histology of the striate lesions in the palms, where they had existed some eight or nine years. Johnston found the changes limited to the superficial part of the corium, where the cells were distributed in foci along the vessel plexus. He holds that the process is neoplastic and not, as in X. diabetorum, inflammatory, and that the cells are of endothelial origin, tending to undergo granulo-fatty degeneration.

In a second case *showing enormous development of tuberoso lesions* a section from a tumour showed the entire corium replaced by the new growth, which hardly infiltrated the subcutaneous fat. The growth contained angular spaces enclosing cholesterol before the specimen was hardened.

The author holds there is no kinship between X. vulgare and X. diabetorum, save only the presence of fat, due, in both instances, to a degenerative process.

Whitehouse speaks favourably of the action of X-rays and of blistering with the high-frequency coil.

T. C. F.

ERYSIPELOID, WITH A RECORD OF 329 CASES, OF WHICH 323 WERE CAUSED BY CRAB BITES, OR LESIONS PRODUCED BY CRABS. Professor T. CASPAR GILCHRIST. (*Journ. Cut. Dis., including Syph.*, vol. xxii, No. 266, November, 1904.)

THE author follows up a paper read in 1896 by a further account of a dermatitis due to bites or injuries from crabs, which is fairly common in Baltimore in the summer crab season. He attaches this affection to the erysipeloid of Rosenbach, which is most frequently met with in cooks, kitchen workers, butchers, and those who handle game, fish, cheese, and herrings.

Gilchrist practically always obtained a history of a bite or injury from a crab. Within a few days, in most cases two days, a painful, red, hot swelling appears about the injured part of the finger, thumb, or hand. As the dermatitis advances the characteristic slightly raised margin retains its definite bright red outline. There is an absence of papules, vesicles, and pustules, and desquamation does not follow. There are no constitutional symptoms and rarely glandular enlargement.

Histologically the inflammation was found to be of a simple type and to involve the whole corium, and slightly the hypoderm, picking out the sweat-ducts. No micro-organisms could be found, and all culture and inoculation experiments yielded negative results. Gilchrist discusses the possibility of a special ferment being the agent.

T. C. F.

QUARTERLY SURVEY OF DERMATOLOGICAL LITERATURE.

HYPERÆMIAS AND INFLAMMATIONS.

- Cutaneous Diphtheria**, A Case of Extensive, with an Examination of the Nervous System. C. BOLTON and D. BREWER. (*Lancet*, April 29th, 1905, p. 1131.)
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- Granulosis Rubra Nasi**. H. MALHERBE. (*Journ. de Mal. Cut. et Syph.*, February 1905, tome xvii, No. 2, p. 96.)
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- Malleus Acutus**, A Case of. P. L. BOSELLINI. (*Archiv f. Derm. u. Syph.*, March, 1905, lxxiv, p. 41.) Three Plates.
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- Paget's Disease (?) of the Gluteal Region**: The Effects of the Röntgen Rays upon the Disease. J. A. FORDYCE. (*Journ. of Cut. Dis.*, May, 1905, p. 193.)

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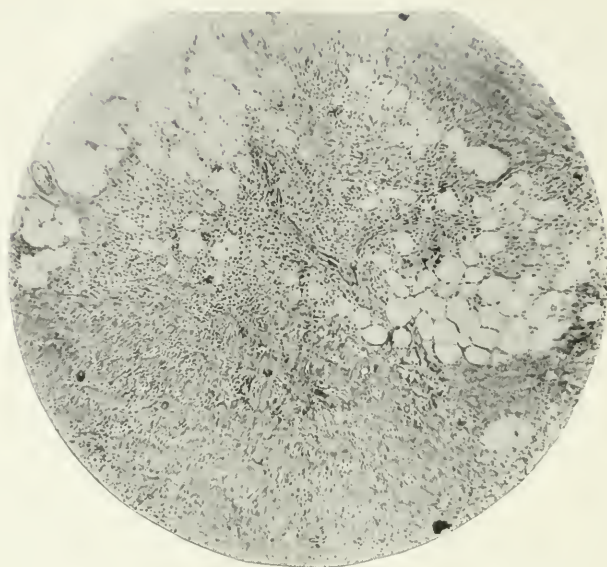


FIG. 1.

SARAH T. NODULE FROM LEG.

SWIFT 1 IN., 8 COMP. OC., STAIN, HÆMALUM-HANSEN.

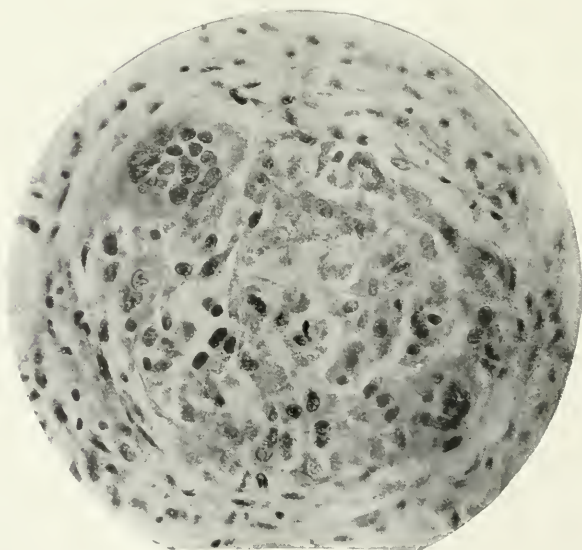


FIG. 2.

SARAH T. NODULE FROM LEG.

SWIFT $\frac{1}{2}$ IN., 4 COMP. OC., STAIN, HÆMALUM-HANSEN.

TO ILLUSTRATE DR. A. WHITFIELD'S ARTICLE.

THE BRITISH JOURNAL OF DERMATOLOGY.

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A FURTHER CONTRIBUTION TO OUR KNOWLEDGE OF ERYTHEMA INDURATUM.

BY ARTHUR WHITFIELD, M.D.LOND., F.R.C.P.

(From the Pathological Laboratory, King's College.)

At the meeting of the British Medical Association in 1901 (1), in the Dermatological Section, I read a paper on the above subject, in which I tried to show that, although the views held as to the nature of Erythema induratum were still divergent, only a limited number of authors had attempted to work out the real pathology of the eruption, and that most of the explanations offered were in the nature of pious opinions. By the light of two cases of my own, and by classifying the published cases of others, in which pathological details had been worked out, I came to the conclusion that there were two well-defined types of the disease—one tubercular and the other non-tubercular, the latter occurring usually, though not invariably, in older patients than the former, running a more rapid course, showing less tendency to ulcerate, and causing much more pain. In order to be certain that the case which I considered to belong to the latter class of Erythema induratum was one in which there would be general agreement as to the clinical diagnosis, I brought this patient before the Dermatological Society of London, on which occasion my diagnosis was confirmed by all those members who had the opportunity of examining the patient. The interest which this case aroused in me kept me carefully on the look-out for another case of similar nature,

but it was not until comparatively recently that I had the opportunity afforded me of investigating a second case. Another point was that, owing to the rapid involution of the nodules in the first case, the material which I obtained for investigation was not in as active a condition as could be desired, and I was therefore extremely anxious to get hold of a case for examination before it reached the stage of involution. This second case fulfilled these conditions so admirably that I deem it worthy of reporting, as throwing some further light on the obscure process in question.

Sarah T—, a Polish Jewess, was referred to me by the courtesy of my colleague Dr. Raymond Crawford, suffering from an eruption of nodules beneath and in the skin. The patient was aged 39 years, well nourished, and in apparently fair health. She was married and had four children, and no miscarriages had occurred. Her mother had died of heart disease, her father was living at the age of 82 years. There was no history suggestive of tuberculosis in any of the family, but some of her children suffered from enlarged tonsils and rickets. The patient herself had suffered from typhoid fever in Poland at the age of 9 years, and had been laid up for one month with acute rheumatism in England seven years ago. Since this latter disease she had never been quite well, constantly suffering from pains and aching in the limbs and headache. She also complained that her heart gave her trouble, and she had almost continuous pain in the chest. She stated that she had suffered from lumps in the legs for the last year and that three weeks ago these had become much more numerous, and a similar outbreak had also occurred on the arms and very slightly on the ears. On examination it was found that on the posterior aspects of the calves, more below than above the middle, there were numerous nodules present, varying in size from that of a small dried pea to that of a good-sized hazel-nut. The smaller nodules were not visible, but were at once detected on passing the hand over the skin, while the larger ones definitely involved the skin and showed a faint cyanotic discoloration. There was no definite arrangement with regard to the main subcutaneous veins, but there was no ulceration, and the nodules, though adherent to the skin, were free from the subjacent fascia. The patient complained that they were very tender. On the arms there were also many of these nodules, none being larger than a pea, and except for one on the back of the hand, which was of a

bluish colour, there was no visible discoloration of the skin. They lay almost entirely on the extensor surfaces of the arms and were, like those on the legs, adherent to the skin and movable on the deep fascia. The ears showed in reality no nodules, but the edges were rather cyanotic, as is often seen in patients who suffer with mild degrees of acro-asphyxia.

A careful examination of all the other systems revealed nothing in the slightest degree suggestive of tuberculosis. The heart was rather excitable and its examination caused a marked increase of the pulse rate, but there were no signs of organic disease. The patient was extremely neurotic.

She was admitted to the hospital at once in order that a careful examination might be made into the nature of the nodules. With the patient's consent a nodule from the leg was excised on the day after admission and hardened for histological purposes. In order to test the possibility of tuberculosis it was thought best to use the old tuberculin test as being probably more certain than inoculation for these doubtful forms of tuberculosis, and at the same time giving by the general reaction an indication of any possible latent tubercular focus elsewhere. Accordingly an injection of ·005 c.c. of the original tuberculin was given, and at the same time from the same bottle a patient suffering from undoubted tuberculosis of bone was given a similar injection. The undoubtedly tubercular patient showed a smart rise of temperature of about three degrees, but my patient showed no symptoms at all with the exception of a red urticarial wheal at the site of injection, and this only occurred after the injection of ·01 c.c. a day or two later.

While in the hospital the patient had an attack of hystero-epilepsy, and complained continually of pain after food and flatulence. The nodules subsided fairly quickly while in hospital, and did not return, at all events for some months, after which time I lost sight of her.

The excised nodule, having been hardened in progressive strengths of alcohol, was imbedded in paraffin and entirely cut into sections. For the staining of these the following stains were used: hæmalum-orange-rubin, hæmalum-Hansen, polychrome methylene blue, methyl green-pyronin, carmine-Gran, carmine-Claudius, Ziehl-Neelsen. I may say at once that in no section was any form of organism found. Histologically the nodule was found almost entirely surrounded by

fat, only a few strands of fibrous tissue running up apparently to connect it with the skin above. The nodule itself was composed of two orders of tissue, one being well-established cicatricial fibrous tissue, and the other newly-forming infiltrating tissue spreading into the surrounding fat (see Fig. 1). The former need not detain us. The new-forming tissue was, on the other hand, extremely interesting. At first sight there appeared to lie in it numerous nodules suggestive of thin-walled vessels whose endothelium had proliferated with unusual activity, but on careful examination it was found that these were not vessels, but localised cellular proliferations surrounded by a fine layer of fibrous tissue. Further examination showed that where the inflammatory process spread at its edge the fat cells swelled up and filled out so that they strongly resembled ordinary endothelial cells, some lobules being packed with large proliferating cells which could be easily traced to the original fat cells as their point of origin. In some of the circumscribed collections already mentioned large giant cells were formed, but the appearances were even then not quite like that of tuberculosis (see Fig. 2). The vessels showed the usual infiltration and perivascular changes, such as accompany all chronic inflammatory changes, but they call for no special description. From the appearance and position of this proliferative cell change it would appear that its termination is either in absorption, as in the case of those nodules which entirely disappeared during observation, or in organisation into ordinary cicatricial fibrous tissue, such as was seen in the older portions of the excised nodule. From the clinical history of the case it is evident that even the fairly well formed fibrous tissue was capable of complete absorption, since, when the nodules disappeared they did so without leaving any permanent mark behind, an event which is very striking when one looks at the sections of the older part of the nodule and observes how dense is the fibrous formation. In the case of *Erythema induratum*, which I reported before as being non-tubercular in origin, I noted the presence of marked hysteria and also symptoms referable to the heart, such as palpitation, though no organic disease could be detected. In this case precisely the same train of symptoms was observed; and though, in the absence of further knowledge of the etiology of the disease, it is impossible to attribute to these symptoms any definite cause of relationship, it is, I think, of interest to note their occurrence.

We have, then, to deal with a disease admitted by the members of the Dermatological Society of London to be indistinguishable from Bazin's disease, occurring in women of early middle age and running a much more acute course than that present in young girls, not tubercular in origin, not reacting to doses of old tuberculin which are sufficient to cause a marked reaction in undoubtedly tubercular cases, and not showing a typically tubercular structure on histological examination. As to the cause of this obscure eruption I find that Stockman (2) in an admirable paper on "Chronic Rheumatism" draws attention to the fact that rheumatic nodules are sometimes seen in the subcutaneous tissues and skin apart from fascia and tendons, and also points out that many cases show well-marked dyspepsia and functional nervous symptoms, and it is therefore in this category that I believe these cases belong.

At the time that I reported my first case of non-tubercular nodules I contrasted it with another case, of a young girl, aged 14 years, suffering from what I believed to be truly tubercular nodules on the legs. Owing to certain difficulties inoculation experiments were only carried out when these nodules were resolving, and the experiments were negative in result. From the time when I first took her into the hospital until the present time, four years later, this girl has suffered from attack after attack of these nodules, and although I had tried almost every remedy recommended for the disease, I had never succeeded in cutting short an attack except by putting her to bed and raising the legs, when slow resolution took place. At the end of 1904 she had another smart attack and came up with two ulcers and some nodes which were bluish-red and evidently already liquefied inside. I took her into the hospital and emptied the liquefied nodes, which proved to contain a liquid resembling melted fat, and packed all the cavities with iodoform gauze, under which treatment they very slowly healed, leaving indurated bluish tubercular-looking scars. The material was digested and searched for the tubercle bacillus by Dr. Emery, but none were found. While in the hospital 0.005 c.c. of the old tuberculin was injected for diagnostic purposes, and this was promptly followed by a rigor and a rise of temperature to over 103° thus practically proving the tubercular nature of the disease. Owing to pressure on the beds I had to let her go out as soon as the ulcers were healed though the scars were still infiltrated and cyanotic. One

week after discharge she came up with a new nodule forming over the inner anterior aspect of the right ankle. This was already bluish-pink and adherent to the skin and was about the size of a small hazelnut. Now, in my four years' experience of this case I have never known a node develop without going on to ulceration, and the patient says that resolution has never occurred while she has been about. Of course when taken in and put to bed resolution of small nodules has occurred on more than one occasion.

At this time I was just beginning to work at tuberculosis by means of Wright's method with the testing of the opsonic index of the blood, and I at once took her in hand. On January 16th, 1905, the opsonin index was found to be only $\cdot 35$ of the normal, and accordingly $\frac{1}{800}$ of a milligramme of heated tuberculin R was injected. The next blood examination failed on account of faulty technique, but on January 30th the opsonin index was 1.0. She was given again the same dose, which drove up the opsonin in a week to 1.15, and a week later I gave her a dose of $\frac{1}{400}$, the blood having slid down again to $\cdot 96$. A fortnight later she came again, having failed to come at the end of a week, and I gave another dose of $\frac{1}{300}$, and took her blood for examination. The nodule was almost imperceptible and the old scars were whitening visibly. Here I made an error by giving too large a dose, as I thought in a fortnight she must have dealt with the last, especially as the clinical result was so good. The examination showed an index of $\cdot 89$ only, and had I known that this would be the case I should have waited longer before giving another dose. This error, however, is never serious, as at the worst one only gives one dose too much. On March 6th, a week later, the index was down to $\cdot 77$, and no further dose was given, and on March 13th again no further dose was given, and the blood examination shows that she has dealt very satisfactorily with the dose of February 27th, the index being 2.1. The clinical condition was now as follows: All the scars with one exception were pale, soft, and healthy, and this one, which was very large, had now only a small bluish centre about the size of a hemp seed. The nodule had entirely disappeared to touch, and she had no abnormal sensation there, but there was the slightest pinkness of the skin. The leg was healthier than it had been for four years, and the girl herself felt extraordinarily well. She had been on her legs all the time since she started T.R. treatment.

As far as the Erythema induratum goes, therefore, it is probably at an end for the time, but there are two points to be considered: first, that unless treatment is somewhat prolonged she will slide back again into her old degree of low resistance; secondly, that there is probably some internal focus from which these lesions are derived, although I have been unable to discover it, and unless treatment is prolonged until she has destroyed this, a relapse is almost certain. I therefore propose to continue treatment for some months longer.

I have thought these cases worth a further report, as they tend to establish my previous contention that there is a form of disease indistinguishable from Bazin's disease by ordinary clinical methods, but not tubercular in nature, and also because Case 2 shows, at all events in some of the less virulent forms of tuberculosis, how valuable the treatment by sterilised tuberculin is when accompanied by opsonin measurement. I should like to express my sincere thanks to Dr. Wright for his great kindness in teaching me to follow his delicate and fascinating technique for this measurement of the resisting power, without which treatment by means of tuberculin must lose much of its value, if it does not become actually risky.

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AN INQUIRY INTO THE ÆTIOLOGY OF INFANTILE ECZEMA.

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(Continued from page 221.)

SECTION III.—AN ANALYSIS OF SIXTY CASES OF INFANTILE ECZEMA, WITH COMMENTS—*continued.*

(m) DISTRIBUTION OF ERUPTION. (*Vide* TABLE IV AND FIGS. 1, 2, 3, AND 4).

The following conclusions may be fairly arrived at from a perusal of the Table (IV) and Figs. 1, 2, 3, and 4.



CASE 60



CASE 50



CASE 53



CASE 47 (a)

FIG. 1—Types of distribution on head and face.

CASE 60.—Began at outer angle of left orbit. Duration one month.

CASE 50.—Began on forehead. Duration seven months.

CASE 53.—Began on left cheek. Duration two months.

CASE 47 (a).—Began behind ears. Duration ten and a half weeks.



CASE 15



CASE 33



CASE 39



CASE 47 (b)

FIG. 2.—Types of distribution on head and face.

CASE 15.—Began by right ear. Duration one month.

CASE 33.—Began on right cheek. Duration seven months.

CASE 39.—Began on forehead. Duration three months.

CASE 47 (b).—From same patient as 47 (a), two months later.

1. *Site of first appearance.**—We have seen that this is in almost all the cases on some part of the head or face.

2. *Distribution on trunk.*—The back and abdomen are about equally often affected, the front of chest and neck less so.

3. *Distribution on upper limbs.*—The forearms and hollows of the elbows are the most common places.

4. *Distribution on legs.*—The extensor surface of the legs is the part most commonly affected and next to that the extensor surface of the thighs. The back of the thighs and knees are the least so.

Head and face.—Out of the sixty cases I have diagrammatic outlines of the cranio-facial distribution in forty-six. Of these eight are shown in the illustrations, Figs. 1 and 2.

These diagrams must not be translated into more than they are intended to mean. They give an idea of uniformity in the character of the eruption. Such uniformity did not exist, probably, in any single case. They are intended only to show distribution, and, as far as possible, they do accurately represent the areas of affected skin.

In attempting to group them one finds it very difficult to find any definite means of classification.

Thus, placing the diagrams according to length of duration, one finds that a similar area is affected in Case 46, which had only lasted one week, to what exists in Case 40, which had lasted nearly three years. On the whole, however, the cases which have lasted more than six months, appear to have the scalp less affected than the face. In other words, the eczema on the scalp, whether it appears first or later, seems to tend to disappear sooner than that on the face.

Thus, Case 23 began at the top of the head when four months old; twelve months later the scalp is unaffected, and the face-mask remains. Case 47 began at the back of the ears when six weeks old; thirteen and a half months later these are well, but the face and forehead mask remains. With the exception of these two cases, the rash in all the others remained, when the diagram was made, at the site of the original eruption.

* Besnier (*La Pratique Dermatologique*, vol. ii, pp. 57 *et seq.*) refers in detail to these primary sites of eruption in all classes of eczema. "Régulièrement, alors même qu'il occupera plus tard diverses régions de la surface tégumentaire, l'eczéma commence à un début *localisé*, foyer vaccinal, primaire, localisation maîtresse, élément initial, dont l'importance pratique est considérable."

As regards types of distribution, they may be divided as follows :

Case No.

1. Head mask . . .	27, 44, 8
2. Head mask with lappets . . .	49, 12, 34, 48, 10, 31, 53, 38, 39, 29, 25, 40
3. Face mask . . .	15, 60, 58, 14, 33, 50, 23, 54
4. Head and face mask . . .	51, 5, 47, 45, 13, 17, 30, 36, 52, 24, 35, 51. 32, 4, 42, 43, 55, 57, 37, 41, 28

These types gradually merge into one another, sometimes presenting a distribution which might be placed under either of two types.

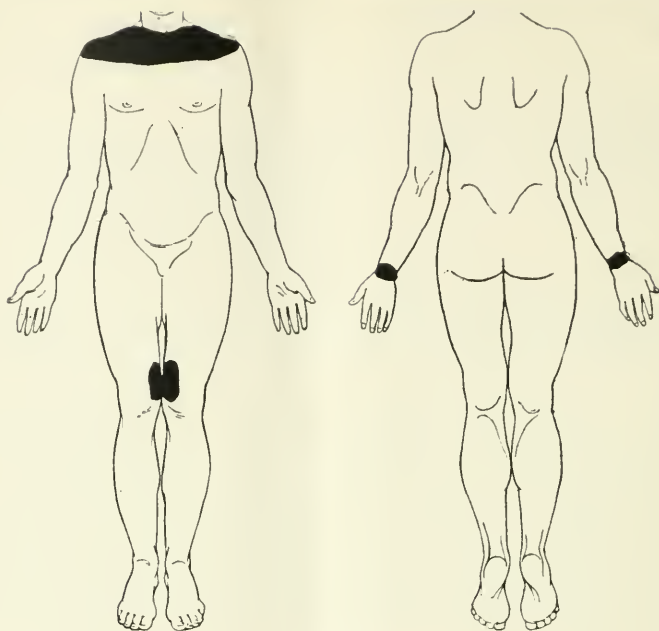
Again, the types may, any of them, be complete or incomplete, patches in these areas being affected which, when grouped together in a diagram, show very strikingly the type arrangement. For instance, Cases 15, 60, 58, 50 are good examples of incomplete Type 3; whilst Cases 5, 9, 12, 13, 25, 29, 30, 31, 36, 45, 47, 49, 51, 53 are all examples of incomplete Type 4. In some of these it will be noticed that the patchy, incomplete part is on the face, in others it is on the head.

It will be noticed that in the type diagrams I have not included the external ear, or the fold of the ear as being affected.

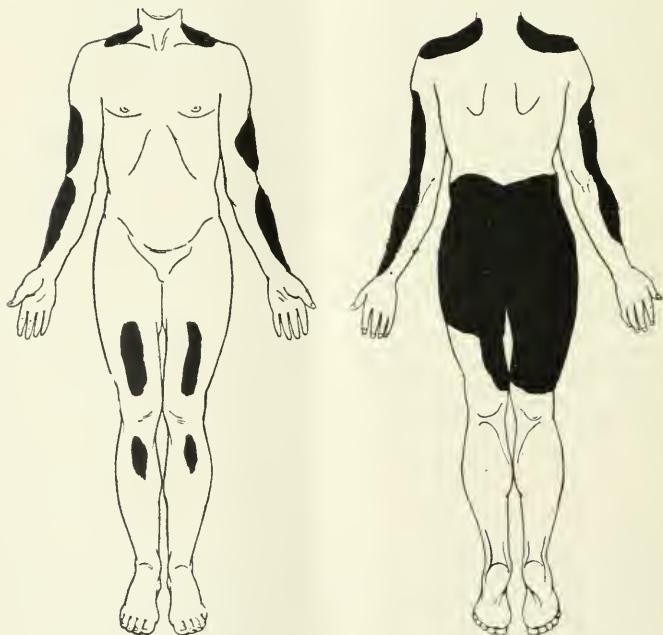
In about half the cases the ears were not affected at the time of making the diagram; in the other half, the extent to which they were involved was variable; thus, sometimes the face mask involves the front of the ear, at others there are fissures in the ear fold above or below. Sometimes one ear is affected, the other not; at others the whole of both lobes is affected. The most striking features, however, of the diagrams are :

(1) The way in which certain areas are almost always affected, whilst other neighbouring areas are exempt; thus the neck, both back and front, is only affected in quite exceptional cases, such as Cases 32, 35, or 37. Again, the frequent exemption of the skin around the eyes, on the nose, and round the lips has struck observers for a long time; hence Unna's name of the "mask with holes cut in it" for these cases. It is true that occasionally these parts are affected, but it is comparatively rare, and usually slight.

(2) The symmetry of the outbreak. This is particularly noticeable in the cases of incomplete facial masks, where, although the patches on

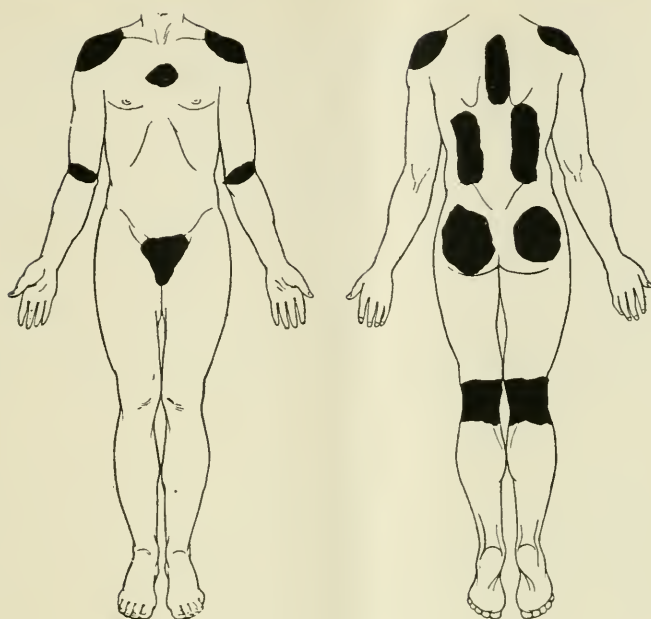


Case 9.

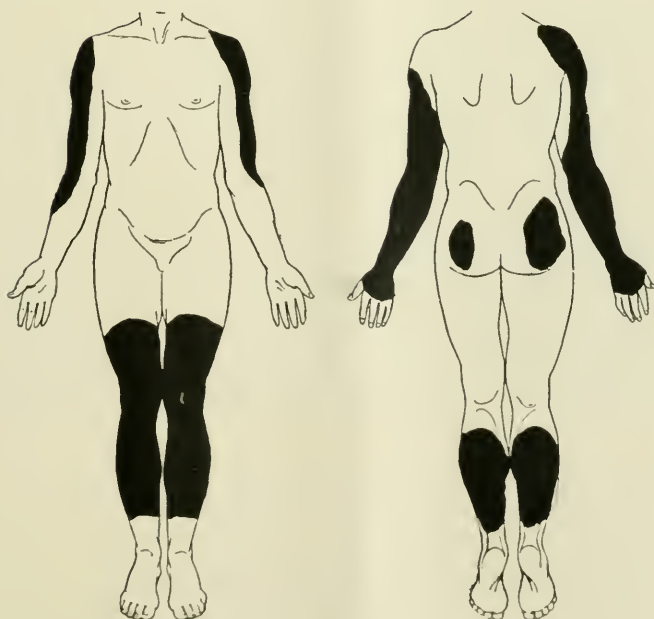


Case 37.

FIG. 3.—Types of distribution on trunk and limbs.



Case 5.



Case 35.

FIG. 4.—Types of distribution on trunk and limbs.

the two sides may vary in size, their correspondence in position is very striking. See especially Cases 15, 60, 53, 50, 47, 45, 9.

This symmetry is equally well shown in many of the more complete cases. It is true that some cases do not show it markedly, but they are comparatively few, and sometimes their very asymmetry, probably representing new areas starting, or old ones which have disappeared, confirms rather than negatives the general symmetrical distribution.

The symmetry is further seen in the trunk and limb distribution, varying with circumstances. The trunk diagrams (Figs. 3 and 4) do not represent whole areas of eczema, but often a patch is merely a series of grouped papules or vesicles.

(n) SUMMARY.

(a) *Sex*.—There were more males than females.

FAMILY HISTORY.

(b) *Age of mother*.—More of the children were born in the middle or late, rather than the early period of maturity.

(c) *Number of other children, etc.*—On the whole, they were not children of very large families. First-borns were not more frequently affected than others. About one half of the cases were either second or third born.

(d) *Evidence of skin disease in mothers*.—Only a very small percentage of mothers had suffered from an actual outbreak of eczema. A considerable number showed stigmata of seborrhœa. Nearly one-half of the mothers had not suffered from any skin disease whatever.

(e) *Evidence of skin disease in children*.—In only a very few cases was any other child of the same family similarly affected in infancy.

DETAILS REGARDING FIRST APPEARANCE OF ERUPTION.

(f) *Age of child*.—Most of the cases began between the end of the first, and the beginning of the fifth month of life.

(g) *Site of first appearance*.—In ninety-five per cent. of the cases the rash appeared first on some part of the head.

(h) *Season of year*.—Out of fifty-nine cases, spread over a period of six years only, three occurred during the quarter June to August, the warmest quarter of the year, whilst twenty-four began in the quarter December to February (the coldest quarter). The number for the quarter September to November was eighteen, for the remaining spring quarter, fourteen.

(i) *Nature of food*.—Eighty-six and a half per cent. of the cases were breast-fed when the rash appeared. The remainder were bottle-fed.

DETAILS AS TO VACCINATION AND DENTITION.

(j) *Vaccination*.—The greater number of the cases had not been vaccinated before the eruption appeared. In those that had been vaccinated, the interval between that and the first appearance of the eruption varied considerably in different cases.

(k) *Dentition*.—In most of the cases the eruption preceded first dentition, often by an interval of months (*vide* also *f*).

CONDITION OF CHILD.

(l) *Evidence of Alimentary Disturbance and Rickets*.—In most of the cases there was no wasting, vomiting, or diarrhoea. In about fifteen per cent. there was well-marked rickets, in more than fifty per cent. there was none.

(m) *Character and Distribution of Eruption*.—The character varied according to the duration, cleanliness, amount of secondary infection, etc. The distribution was frequently extensive; certain parts were almost always, others hardly ever, affected. The symmetry of the eruption on the two sides of the body, in all parts affected, was usually noticeable.

TABLE I.

Case No.	Age of mother.	Number of other children.	Time since previous confinement.	Other children.		
				With eczema.	With uncertain skin disease.	With no skin disease.
1	23	1	2 years	0	0	1
2	29	3	?	0	1	2
3	33	2	8½ years	0	0	2
4	?	?	?	1	?	?
5	24	?	?	0	0	?
6	39	3	6½ years	0	0	3
7	29	4	2 "	0	1	3
8	32	2	?	0	1	1
9	20	0	—	0	0	0
10	34	4	3 years	0	0	4
11	26	2	2½ "	0	0	2
12	24	0	—	0	0	0
13	29	2	2 years	0	0	2
14	28	2	7½ "	0	1 twin	1
15	24	3	2 "	0	0	3
16	40	5	?	0	0	5
17	27	2	1½ years	0	0	2
18	33	3	1½ "	0	0	3
19	23	?	?	?	?	?
20	33	5	?	0	0	5
21	28	1	2¾ years	0	0	1
22	20	?	?	?	?	?
23	36	5	5 years	0	0	5
24	34	2	5½ "	1	0	1
25	28	4	3 "	0	0	4
26	28	1	2 "	0	1	0
27	24	2	3½ "	0	0	2
28	34	3	13½ "	0	0	3
29	30	3	2½ "	0	0	3
30	29	2	2½ "	0	0	2
31	23	0	—	0	0	0
32	26	0	—	0	0	0
33	37	1	?	0	1	0
34	33	3	2¾ years	0	0	3
35	37	2	3½ "	0	0	2
36	35	3	3½ "	0	0	3
37	42	4	1½ "	0	0	4
38	30	1	4¾ "	0	0	1
39	26	1	1 year	0	0	1
40	22	1	younger	0	0	1
41	39	5	3¾ years	0	0	5
42	27	2	2½ "	0	1	1
43	36	6	1¾ "	0	0	6
44	23	2 dead	?	0	0	2
45	28	2	2 years	0	0	2
46	35	1	8½ "	0	0	1
47	31	2	3 "	0	0	2
48	29	4 dead	?	0	0	4
49	?	1	2½ years	0	0	1
50	21	0	—	0	0	0
51	21	1	2¾ years	0	0	1
52	?	1 dead	?	0	1	0
53	?	0	—	0	0	0
54	36	5	2½ years	0	0	5
55	28	1	7 "	0	0	1
56	23	0	—	0	0	0
57	29	3	2½ years	0	0	3
58	23	2	?	0	0	2
59	?	2	?	1	1	0
60	20	0	—	0	0	0

TABLE II. *Evidence of Skin Disease in Mother.*

Case No.	Definite outbreak of eczema.	Indefinite past or present skin disease.	Case No.	Definite outbreak of eczema.	Indefinite past or present skin disease.
1	—	—	30	—	—
2	Yes; infancy	—	31	—	—
3	?	?	32	—	—
4	—	Rash in head each spring; scaly patches nose and chin.	33	—	—
5	—	Dry red scaly patches cheeks and sides of neck.	34	Yes; 2 years ago	—
6	—	Rash when pregnant, dry scaly face.	35	—	Scurfy face in summer.
7	?	?	36	—	—
8	—	Blotches on face; dry scales on nose, chin, and cheeks.	37	?	?
9	—	—	38	—	Dryness on face.
10	—	Bad hands a year ago.	39	—	Scurf on face in summer.
11	—	—	40	—	—
12	—	Dry skin of face.	41	—	—
13	?	?	42	Yes; seborrhoeic	Still has patches behind right ear and on neck.
14	—	Face scurfy in winter.	43	—	—
15	—	Bad ear when child.	44	—	Right cheek dry and scaly.
16	—	—	45	—	Dry patches at angles of mouth.
17	—	—	46	—	Rough patch behind right ear.
18	—	—	47	—	Scurf on temples and neck.
19	?	?	48	—	—
20	—	Dry scaly patches at hair roots, with crusts; rosacea.	49	Yes; 5 years ago	Now has eczema of ears and scalp.
21	Yes; all life	Face dry and scaly.	50	—	—
22	—	—	51	—	—
23	—	Dry scaly patches at corner of mouth.	52	?	?
24	—	—	53	—	—
25	—	—	54	—	—
26	—	—	55	—	—
27	—	Dry scaly face always.	56	Yes; 5 years ago	Still has remains on neck and ears.
28	—	—	57	—	Rosacea, dry red patches on cheeks.
29	—	Rash on face after vaccination.	58	—	Inflamed eyelids; dry red patches on cheeks.
			59	—	Scurfy face and head; dry hands in winter.
			60	Yes; infancy	—

TABLE III. *Nature of Food when Rash first appeared.*

Case No.	Age when rash first appeared.	Breast and other food.	Breast only.	Bottle only.	Age when weaned.
	Months.				Months.
1	5	Yes; crusts	—	—	7
2	8	—	Yes	—	12
3	14	—	Yes	—	—
4	$\frac{1}{2}$	—	Yes	—	—
5	3	—	Yes	—	—
6	3	—	Yes	—	—

TABLE III. *Nature of Food when Rash first appeared*—continued.

Case No.	Age when rash first appeared.	Breast and other food.	Breast only.	Bottle only.	Age when weaned.
	Months.				Months.
7	3	—	Yes	—	7
8	6	?	—	—	—
9	1	Yes; Neave's, crusts	—	—	—
10	2	—	Yes	—	—
11	2	Yes; bread and milk	—	—	—
12	6	Yes; bread, rusks	—	—	—
13	3	Yes; bread, biscuits	—	—	—
14	2	Yes; rusks	—	—	—
15	12	—	—	Yes	3
16	5	Yes; bread in tea	—	—	—
17	3	—	Yes	—	—
18	2 $\frac{1}{4}$	—	Yes	—	—
19	7	Yes; bread, biscuits	—	—	—
20	1 $\frac{3}{4}$	Yes; biscuits	—	—	—
21	3	Yes; ? what	—	—	—
22	3	—	—	Yes	—
23	4	—	Yes	—	—
24	3 $\frac{3}{4}$	—	Yes	—	—
25	1 $\frac{3}{4}$	—	Yes	—	—
26	2 $\frac{1}{4}$	—	Yes	—	—
27	4	—	Yes	—	—
28	2 $\frac{1}{2}$	Yes; Mellin's	—	—	—
29	2 $\frac{1}{2}$	Yes; milk and sago	—	—	—
30	1	Yes; ? what	—	—	—
31	2 $\frac{1}{2}$	—	Yes	—	—
32	1 $\frac{1}{2}$	—	Yes	—	—
33	3	—	—	Yes	?
34	3 $\frac{1}{2}$	—	Yes	—	—
35	1	Yes; ? what	—	—	—
36	3	—	Yes	—	—
37	3	—	—	Yes	1 $\frac{1}{2}$ (Swiss milk).
38	4	—	Yes	—	—
39	3 $\frac{3}{4}$	—	Yes	—	—
40	2 $\frac{3}{4}$	—	Yes	—	—
41	1	—	Yes	—	—
42	3	—	Yes	—	—
43	3	Yes; rusks	—	—	—
44	6	—	Yes	—	—
45	3	—	—	Yes	1 $\frac{1}{2}$ (milk and barley-water).
46	4	—	—	Yes	Birth (milk and Neave's).
47	1 $\frac{1}{2}$	—	Yes	—	13
48	3	—	Yes	—	—
49	1 $\frac{1}{2}$	—	Yes	—	—
50	2	—	Yes	—	—
51	4 $\frac{1}{4}$	—	Yes	—	—
52	1	—	Yes	—	—
53	2	Yes; milk only	—	—	—
54	3	—	Yes	—	—
55	3	—	Yes	—	—
56	11	—	—	Yes	10 (milk and bread).
57	3	Yes; milk and rusks	—	—	—
58	1 $\frac{3}{4}$	—	Yes	—	—
59	3	Yes; cooked bread	—	—	12
60	2	—	—	Yes	? (milk and barley-water).

In this table — signifies negative.

TABLE IV. *Distribution and First Site of Eruption.*

Case No.	Duration of Rash (Months).	Place First Affected.	Distribution when first seen by me.					
			Scalp.	Foreh'd	Cheeks.	Trunk.	Arms.	Legs.
1	6	Body.	0	+	+	+	+	+
2	12	Left cheek.	+	+	+	?	?	?
3	5½	Left cheek.	+	+	+	+	?	?
4	2	Occiput.	+	?	?	?	?	?
5	6	Forehead.	+	+	+	+	+	+
6	3	Vertex.	+	+	+	+	+	+
7	6	Head.	+	0	0	0	0	0
8	30	Scalp.	+	0	0	+	0	+
9	6	Cheeks.	+	0	+	?	?	?
10	1	Head.	+	+	+	+	+	+
11	3	Right cheek.	0	+	+	+	+	+
12	1	Vertex.	+	+	+	+	0	+
13	30	Right cheek and ear.	+	+	+	0	+	+
14	5	Left ear.	+	0	+	+	0	0
15	1	Right ear.	0	+	+	0	0	0
16	5	Occiput.	+	+	0	0	0	0
17	4	Forehead.	+	+	+	0	0	0
18	1¼	Left cheek.	+	+	+	0	0	0
19	2	Big toe.	?	?	?	?	?	+
20	?	Right cheek.	+	+	+	+	+	0
21	0	Right cheek.	+	?	+	?	+	?
22	2	Vertex.	+	+	?	?	?	?
23	12	Vertex.	+	+	+	+	+	0
24	4¼	Right and left cheek.	+	+	+	0	0	0
25	22¼	Left cheek.	+	+	+	0	+	0
26	33¼	Left cheek.	+	+	+	+	+	+
27	0	Head (front).	+	+	+	+	+	+
28	3½	Forehead, cheeks.	+	+	+	0	0	0
29	4½	Left cheek.	+	+	+	+	0	+
30	4	Forehead.	+	+	+	0	0	0
31	2	Head, right cheek.	+	+	+	0	0	0
32	4½	Eyebrows.	+	+	+	+	0	+
33	7	Right cheek.	0	+	+	+	+	0
34	½	Occiput.	+	+	+	0	0	0
35	4	Right cheek.	+	+	+	+	+	+
36	4	Vertex.	+	+	+	0	+	+
37	1½	Forehead.	+	+	+	+	+	+
38	2¾	Occiput.	+	+	+	0	0	0
39	3¼	Forehead.	+	+	+	0	0	0
40	33½	Vertex.	+	+	+	0	+	0
41	3	Forehead.	+	+	+	0	0	0
42	0	Vertex.	+	+	+	0	0	0
43	1	Vertex.	+	+	+	+	+	+
44	2	Eyebrows.	+	+	0	0	0	0
45	17	Right cheek.	+	+	+	0	0	0
46	0	Head and face.	+	+	+	0	0	0
47	10½	Behind ears.	+	+	+	+	+	+
48	1	Vertex.	+	+	+	0	0	0
49	½	Forehead.	+	+	0	0	0	0
50	7	Forehead.	+	+	+	+	0	+
51	4½	Vertex.	+	+	+	+	+	0
52	4	Forehead.	+	+	+	0	0	0
53	2	Left cheek.	+	+	+	+	+	+
54	27	Left cheek.	0	+	+	+	+	+
55	1	Vertex.	+	+	+	0	0	0
56	2	Back.	+	+	+	+	+	+
57	1	Right cheek.	+	+	+	+	+	0
58	1½	Behind left ear.	0	+	+	+	0	0
59	15	Face and arms.	0	+	+	+	+	+
60	1	Left cheek.	0	0	+	0	0	0

TABLE V. *Dentition and Vaccination.*

Case No.	Age of child when				Case No.	Age of child when			
	Rash first appeared.	Seen by me.	First tooth cut.	Vaccinated.		Rash first appeared.	Seen by me.	First tooth cut.	Vaccinated.
		Months.	Months.				Months.	Months.	
1	5	11	4	?	31	2½	4½	—	?
2	8	24	9	?	32	1½	6	2 cut when born, none since	?
3	1½	7	—	?					
4	½	2½	?	?	33	3	10	6	?
5	3	9	6	?	34	3½	4	—	3
6	3	6	—	?	35	1	5	—	?
7	3	9	?	?	36	3	7	—	?
8	6	36	6	?	37	3	4½	—	?
9	1	7	—	?	38	¼	3	—	—
10	2	3	—	?	39	¾	4	—	—
11	2	5	5	?	40	2¾	36	?	?
12	6	7	—	?	41	1	4	—	?
13	3	36	10	?	42	3	3	—	2
14	2	7	—	?	43	3	4	—	—
15	12	13	5 (none since)	?	44	6	8	—	3
16	5	10	7	?	45	3	20	13	—
17	3	7	—	2½	46	4	4	—	?
18	2¾	4	—	?	47	1½	12	8	—
19	7	9	5	?	48	3	4	—	?
20	1¾	?	4	?	49	1½	2	—	—
21	3	3	—	?	50	2	9	5	5
22	3	5	—	?	51	4½	9	6	4
23	4	16	12	?	52	1	5	?	?
24	¾	5	—	?	53	2	4	—	1
25	1¾	24	7	1½	54	3	30	6	—
26	2¼	36	5	?	55	3	4	—	—
27	4	4	—	?	56	11	13	7	1
28	2½	6	—	2¼	57	3	4	—	—
29	2½	7	?	?	58	1¾	3	—	1½
30	1	5	—	1(3 days before).	59	3	18	9	6
					60	2	3	—	2½

In this table — means *no* tooth cut or *not* vaccinated.

TABLE VI. *Evidence as to Digestive Troubles.*

Case No.	Vomiting.	Diarrhœa.	Wasting.	Case No.	Vomiting.	Diarrhœa.	Wasting.
1	—	—	—	12	—	—	—
2	?	?	?	13	—	Yes.	Yes.
3	—	—	Yes.	14	—	Yes.	—
4	?	?	?	15	—	Yes.	?
5	—	—	—	16	—	—	—
6	—	—	—	17	—	—	—
7	?	?	?	18	—	—	—
8	—	—	—	19	?	—	Yes.
9	—	—	—	20	?	?	?
10	—	—	—	21	?	—	?
11	—	—	—	22	—	—	—

TABLE VI. *Evidence as to Digestive Troubles—continued.*

Case No.	Vomiting.	Diarrhœa.	Wasting.	Case No.	Vomiting.	Diarrhœa.	Wasting.
23	—	Yes.	—	42	—	—	—
24	—	—	Yes.	43	—	—	—
25	—	—	—	44	—	—	—
26	—	—	—	45	—	—	—
27	Yes.	—	—	46	—	—	—
28	—	Yes.	—	47	—	—	—
29	—	—	Yes.	48	—	—	—
30	—	—	—	49	—	—	—
31	Yes.	—	—	50	—	Yes.	—
32	Yes.	—	—	51	—	—	—
33	—	Yes.	—	52	—	—	?
34	—	—	—	53	—	—	—
35	—	Yes.	—	54	—	—	—
36	—	Yes.	—	55	—	—	—
37	Yes.	—	Yes.	56	—	—	Yes.
38	?	?	—	57	—	—	Yes.
39	—	Yes.	—	58	—	—	—
40	—	—	?	59	—	—	—
41	—	—	—	60	—	—	—

In this table — signifies negative.

TABLE VII. *Evidence of Rickets when Child first seen.*

Case No.	Duration of rash.	Beaded ribs.	Enlarged joints.	Sweating of head.	Prominent belly.	Case No.	Duration of rash.	Beaded ribs.	Enlarged joints.	Sweating of head.	Prominent belly.
Months.						Months.					
1	6	—	Yes	Yes	—	31	2	—	—	Yes	—
2	12	Yes	Yes	?	—	32	4½	Yes	—	—	Yes
3	5½	Yes	—	Yes	—	33	7	Yes	Yes	—	—
4	2	—	—	—	—	34	1½	?	?	?	?
5	6	Yes	Yes	—	Yes	35	4	?	?	?	?
6	3	Yes	—	—	?	36	4	—	—	—	—
7	6	?	?	?	?	37	1½	Yes	—	—	Yes
8	30	?	?	?	?	38	2½	Yes	Yes	—	—
9	6	Yes	—	Yes	Yes	39	3½	—	—	—	—
10	1	Yes	Yes	Yes	?	40	33½	Yes	—	Yes	Yes
11	3	—	—	Yes	?	41	3	—	—	—	—
12	1	Yes	Yes	—	?	42	—	?	?	?	?
13	30	?	?	?	?	43	1	—	—	—	—
14	5	Yes	Yes	Yes	Yes	44	2	—	—	—	—
15	1	Yes	—	Yes	Yes	45	17	Yes	Yes	Yes	Yes
16	5	Yes	?	Yes	Yes	46	—	Yes	—	—	—
17	4	Yes	Yes	Yes	?	47	10½	—	—	Yes	—
18	1½	?	—	—	—	48	1	—	—	Yes	—
19	2	—	—	?	—	49	1½	?	?	—	?
20	?	?	?	?	?	50	7	?	?	Yes	?
21	—	—	—	—	—	51	4½	—	—	—	—
22	2	Yes	—	—	—	52	4	?	?	?	?
23	12	Yes	Yes	—	Yes	53	2	—	—	—	—
24	4½	—	—	—	—	54	27	—	—	—	—
25	22½	?	?	?	?	55	1	—	—	—	—
26	33½	Yes	Yes	Yes	Yes	56	2	—	—	—	—
27	—	Yes	Yes	—	—	57	1	—	—	—	—
28	3½	—	—	—	—	58	1½	—	—	—	—
29	4½	?	—	Yes	—	59	15	?	?	?	?
30	4	Yes	Yes	Yes	—	60	1	—	—	—	—

In this table — signifies negative.

TABLE VIII. *Month of Birth and of Appearance of Eruption.*

Case No.	Born.	Rash first seen.	Case No.	Born.	Rash first seen.
1	April, 1898	September, 1898	34	June, 1901	September, 1901
2	February, 1897	October, 1897			(end)
3	June, 1898	August, 1898	35	October, 1901	November, 1901
4	January, 1899	January, 1899	36	July, 1901	October, 1901
5	July, 1898	October, 1898	37	August, 1901	December, 1901
6	October, 1898	November, 1898	38	December, 1901	December, 1901
7	August, 1898	November, 1898	39	April, 1902	May, 1902
8	?	?			(Whit-Tuesday,
9	October, 1898	November, 1898			a bitterly cold,
10	March, 1899	May, 1899			wet day).
11	May, 1899	July, 1899	40	October, 1899	January, 1900
12	July, 1899	January, 1900	41	April, 1902	May, 1902
13	October, 1896	January, 1897	42	August, 1902	November, 1902
14	August, 1899	October, 1899	43	September, 1902	December, 1902
15	February, 1899	February, 1899	44	April, 1902	October, 1902
16	May, 1899	October, 1899	45	June, 1901	September, 1901
17	September, 1899	December, 1899			(end)
18	December, 1899	January, 1900	46	September, 1902	January, 1903
19	June, 1898	January, 1900	47	March, 1902	April, 1902
20	August, 1898	September, 1898	48	December, 1902	March, 1903
		(last week)	49	February, 1903	April, 1903
21	July, 1898	October, 1898	50	August, 1902	October, 1902
22	January, 1899	April, 1899	51	August, 1902	December, 1902
23	October, 1898	February, 1899	52	September, 1902	October, 1902
24	March, 1901	March, 1901	53	December, 1902	February, 1903
25	November, 1898	January, 1899	54	November, 1900	February, 1901
26	November, 1897	January, 1898	55	February, 1903	May, 1903
27	July, 1900	November, 1900			(very cold in first
28	October, 1900	January, 1901	56	May, 1902	April, 1903
		(living at very	57	February, 1903	May, 1903
		exposed, bleak			(see above).
		place on hills	58	March, 1903	May, 1903
		temporarily).			(early) see above.
29	September, 1900	December, 1900	59	October, 1901	January, 1902
30	December, 1899	January, 1900	60	May, 1903	July, 1903
31	February, 1900	April, 1900			(towards end,
32	December, 1899	February, 1900			when weather
33	December, 1900	March, 1901			turned very cold)

TABLE IX. *Cases Grouped according to Age when Rash first appeared.*

Case No.	Month of birth.	Month of rash appearing.	Case No.	Month of birth.	Month of rash appearing.
	(a)	DURING FIRST MONTH OF LIFE.		(b)	DURING SECOND MONTH OF LIFE.
4	January	January.	6	October	November.
15	February	February.	9	October	November.
24	March	March.	18	December	January.
38	December	December.	20	August	September (end).

TABLE IX. *Cases Grouped according to Age when Rash first appeared—continued.*

Case No.	Month of birth.	Month of rash appearing.	Case No.	Month of birth.	Month of rash appearing.
	(b)	DURING SECOND MONTH OF LIFE— <i>cont.</i>		(d)	DURING FOURTH MONTH OF LIFE— <i>cont.</i>
30	December	January.	22	January	April.
35	October	November.	28	October	January.
39	April	May (very cold Whit-Tuesday, 1902).	30	September	December.
41	April	May (1902).	33	December	March.
47	March	April.	34	June	September.
52	September	October.	36	July	October.
	(c)	DURING THIRD MONTH OF LIFE.	40	October	January.
3	June	August (after day at Cleethorpes).	42	September	December.
10	March	May.	43	September	December.
11	May	July.	45	June	September (end).
14	August	October.	48	December	March.
25	November	January.	54	November	February.
26	November	January.	55	February	May (1903).
31	February	April.	57	February	May (1903).
32	December	February.	59	October	January.
49	February	April.		(e)	DURING FIFTH MONTH OF LIFE.
50	August	October.	23	October	February.
53	December	February.	27	July	November.
58	March	May (1903).	37	August	December.
60	May	July (1903).	46	September	January.
	(d)	DURING FOURTH MONTH OF LIFE.	51	August	December.
5	July	October.		(f)	DURING SIXTH MONTH OF LIFE OR LATER.
7	August	November.	1	April	September.
13	October	January.	2	February	October.
17	September	December.	12	July	January.
21	July	October.	16	May	October.
			19	June	January.
			44	April	October.
			56	May	April.

TABLE X. *Cases Grouped according to Month of Birth.*

Month of birth.	Month of Appearance of Rash.												Total.
	Jan.	Feb.	Mar.	Apr.	May.	June.	July.	Aug.	Sept.	Oct.	Nov.	Dec.	
January.	1	—	—	1	—	—	—	—	—	—	—	—	2
February.	—	1	—	2	2	—	—	—	—	1	—	—	6
March.	—	—	1	1	2	—	—	—	—	—	—	—	4
April.	—	—	—	—	2	—	—	—	1	1	—	—	4
May.	—	—	—	1	—	—	2	—	—	1	—	—	4
June.	—	1	—	—	—	—	—	1	2	—	—	—	4
July.	—	1	—	—	—	—	—	—	—	3	1	—	5
August.	—	—	—	—	—	—	—	—	1	2	1	1	5
September.	—	1	—	—	—	—	—	—	—	1	—	4	6
October.	—	4	1	—	—	—	—	—	—	—	3	—	8
November.	—	2	1	—	—	—	—	—	—	—	—	—	3
December.	—	2	2	2	—	—	—	—	—	—	—	1	7
													58

(To be concluded.)

SOCIETY INTELLIGENCE.

THE DERMATOLOGICAL SOCIETY OF LONDON.

A MEETING of this Society was held on Wednesday, June 14th, 1905, Dr. J. J. PRINGLE in the chair.

Dr. DORE showed a case of *Rodent ulcer* for Mr. Malcolm Morris. The patient, a woman aged 47 years, had a rodent ulcer of twenty years' duration affecting the skin of the angle of the mouth and the adjacent buccal mucous membrane.

The ulcer had healed satisfactorily under X-rays, but fresh outbreaks had occurred from time to time in the mucous membrane, and, owing to unavoidable neglect of treatment, there had been a recent extension to the mucous membrane of the lower lip and a new deposit, beginning in the mucous membrane of the upper lip, previously unaffected. The cavity at the angle of the mouth had also broken down again. The treatment of the disease inside the mouth presented great difficulties on account of the contraction of the scar preventing the mouth being opened. X-rays and radium had been used on and off for nearly three years, and had kept the disease in check, but relapses had invariably occurred. The case was not a favourable one for surgical procedures, but in view of the obstinate character of the disease when it attacked mucous membrane and bone, excision was recommended by some of the members present.

Dr. GRAHAM LITTLE showed: (1) A case of *Urticaria pigmentosa* in a little girl, aged $2\frac{1}{2}$ years. The eruption had been noticed by the mother at the first washing of the child, some two weeks after birth; she could not be positive that it was not present at the birth, but the midwife who had looked after the child until the mother was able to do so had not remarked anything abnormal about the skin. It was, at any rate, certain that the eruption was not nearly so thickly present in the earlier weeks of her life as it had afterwards become. There was but little itching and the child was in otherwise excellent health. There was no family history of importance.

(2) A case of *Epithelioma* of the right angle of the mouth in an old Irishman, aged 72 years, who gave the following account of the disease. He had not had any pain in connection with it, and it had begun to discharge and break down only in the last seven months,

but there had been a swelling in this position for about three years. It was certainly astonishing that there was no perceptible glandular enlargement in association with the part affected, and this fact, together with a doubtful history of some improvement under treatment, had led to some question whether the disease was not possibly syphilitic. But a section from the skin had demonstrated without any ambiguity the existence of an epithelioma. The process was now invading the lip, which was considerably infiltrated.

(3) A case of *Myoma cutis* in a middle-aged woman who had had the small tumours which were now noticeable for about three to six months. This case will be reported more fully in a future issue of this journal.

Mr. GEORGE PERNET showed a microscopic specimen of *Streptothrix* (actinomyces) from a case of actinomycosis under the care of Dr. Radcliffe-Crocker. The patient was a gentleman, who had a brawny infiltrated area, with soft fluctuating points about it over the left hip. The preparation stained by gram-eosin brought out very clearly the characteristic appearances of streptothrix, viz. mycelial elements, very numerous in this instance, aggregated here and there into felted masses, but there were no rosettes of clubs such as occur chiefly in actinomycosis of cattle (*Actinomyces bovis*). A good many species of streptothrix had been described at one time and another.*

Dr. J. J. PRINGLE brought forward (1) a case of *Lichen plano-pilaris* in a girl, aged 14 years, the disease being of two years' duration. The nomenclature adopted was that referred to by Dr. Adamson in his recent paper on *Lichen pilaris* (*British Journal of Dermatology*, vol. xvii, No. 3, 1905, p. 78) as employed by the exhibitor in 1895, and the case was a typical one of its class. On the back of the neck was a roughly circular patch of conglomerate lichen, showing much atrophy, and surrounding it were numerous acuminate follicular lesions. The chief manifestations, however, were on the inner sides of both knees, and consisted of large, deeply infiltrated purple plaques, each the size of the palm of the hand. The edges were composed of prominent spiny acuminate papules, which extended two or three inches round the plaques in every direction, becoming more and more

* See, among others, Foulerton and Price-Jones, in *Path. Soc. Trans.*, vol. liii, 1902, p. 56, also Foulerton's subsequent paper before the same Society, May 2nd, 1905.

discrete and less prominent as they spread down the legs; but every follicle as far down as the ankle exhibited some degree of keratosis.

(2) A peculiar *Follicular keratosis* of five years' continuous duration in a girl, aged 20 years, otherwise healthy. The disease was confined to the trunk, being more marked in its posterior than its anterior aspect. Every follicle appeared to be involved, and before treatment with salicylic acid minute horny spines studded the whole of the affected surface. At first sight the diagnosis of a syphilitic or tuberculous lichenoid rash suggested itself, but further examination negatived both views. There was a moderate degree of itching, but no visible scratch marks. The exhibitor was unable to classify the case, and no member present was able to assist him in doing so.

Dr. RADCLIFFE-CROCKER showed a case for diagnosis—? *commencing Pityriasis rubra pilaris*. The patient, a woman aged fifty-one, had suffered from the eruption for six months. The front of the knees showed a patch on each, which was symmetrical, three inches in diameter, very hard, was covered with adherent scales and looked very like the knee-patches often seen in *Pityriasis rubra pilaris*. Besides these, on the inner side of the right thigh only, there were follicular papules. The most recent lesions were in irregular groups of a dozen or so, were pale red in colour, and had only been present two or three weeks; but the older portion occupied the upper two thirds of the thigh, and here the papules were closely crowded together and semi-coalescent, forming in the oldest parts lichenified infiltration, with marked hypertrophy of the papillæ. On the border of the infiltration for two or three inches the papules were closely set, but discrete, prominent, and scaly. There was no palmar or plantar affection; in fact, the rest of the skin was free except a band of about three inches long on the extensor aspect of the forearm, made up of papules closely set and of a pale-red colour.

While some of its features suggested *Pityriasis rubra pilaris*, so many of the usual criteria were absent that members of the Society did not make a conclusive diagnosis.

Dr. SEQUEIRA showed a woman, aged 46 years, suffering from *Darier's disease*, described as follows: Eight years ago some red spots appeared on the extensor aspect of both forearms and in the flexures of the elbows. The eruption extended to the hands and between the

fingers. There was a good deal of irritation, especially in the warm weather. The disease gradually spread to the chest, abdomen, and thighs. The back had always been free.

The eruption on the arms and chest consisted of small, closely-placed, reddish-brown papules. On the inner side of the thighs and lower abdomen the spots were larger and more warty in character, and in some parts were confluent. They were quite dry and of a greyish-brown hue. On removal of the horny caps no cup-shaped depressions were found. The scalp was covered with dirty-greyish scales, but there had been no noticeable loss of hair.

The microscopic sections showed the epidermal thickening, but the characteristic cells were but few in number.

There was no evidence of internal disease. The patient was married, and had had ten children, of whom four were alive. There had been two miscarriages and two still-births. There was no history or evidence of syphilis. The husband was a labourer, and the patient had always lived in Limehouse. She was rather taciturn, but her mental condition was not defective.

Dr. WHITFIELD showed a man, aged 47 years, with multiple *Myoma cutis*. The history given was that between five and six years ago a sudden eruption of blisters had occurred in the affected region. The onset was unaccompanied by pain and the lesions that then appeared had never gone away, while others had been slowly coming since. On examination it was found that there were multiple small tumours, varying in size from that of a large pin's head to that of a small pea, situated on a triangular area over the right side of the forehead, the apex of the triangle being downwards. On consultation of a chart of the nerves of the face it was found that this area corresponded almost exactly with that of the external branch of the right supra-orbital nerve, though the tumours did not extend backwards into the hair as far as this branch was distributed. The tumours were of a reddish-brown colour and extremely translucent, so much so that Mr. Lenthal Cheate, to whom Dr. Whitfield was indebted for the case, had thought it might be a case of *lymphangioma*. On piercing one of these tumours with a sterile pointed pipette, however, it was found that there was no fluid to be obtained. There was no pain or tenderness on pressure.

Dr. Whitfield said on first seeing the case he had been in doubt as to the diagnosis. He had thought it possible that they might be some peculiar, possibly colloid, degeneration of the scars of an old Herpes zoster or they might be myomata. A biopsy had been made at once, and the specimen (exhibited) showed that the tumour was a myoma forming a lenticular infiltration of the corium. The tumour came very near the surface, leaving only a very narrow band of loose fibrous tissue between itself and the epidermis, and this was probably the reason for the extreme translucency. It was far too large and too diffuse to allow of any conclusions being drawn as to its point of origin. It was suggested that the X-rays might be tried as a means of removal and this Dr. Whitfield promised to do and to report later.

THE DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.

THE Annual Meeting was held at 11, Chandos Street, on Wednesday, May 24th, Dr. H. Waldo, the President, in the Chair.

The following gentlemen were elected as officers for the session 1905-1906:

PRESIDENT.—H. Waldo, M.D.

PRESIDENT-ELECT.—H. Leslie Roberts, M.D.

VICE-PRESIDENTS.—Wallace Beatty, M.D.; H. A. G. Brooke, M.D.; A. Eddowes, M.D.; E. Graham Little, M.D.; J. F. Payne, M.D.; George Pernet, M.R.C.S.; P. H. Pye-Smith, M.D.; J. H. Stowers, M.D.

TREASURER.—C. H. Thompson, M.D.

HON. SECRETARIES.—Edward Stainer, M.B.; Spencer Hurlbutt, M.R.C.S.

COUNCIL.—P. S. Abraham, M.D.; R. L. Bowles, M.D.; Sir Alfred Cooper, F.R.C.S.; H. Radcliffe Crocker, M.D.; Willmott Evans, F.R.C.S.; W. T. Freeman, M.D.; A. J. Harrison, M.B., J.P.; T. J. P. Hartigan, F.R.C.S.; T. Manners-Smith, M.B.; Norman Meachen, M.D.; Arthur Shillitoe, F.R.C.S.; Wilfrid B. Warde, M.D.

The oration was given by Professor McCall Anderson, who selected for his subject, "A Plea for the More General Use of Tuberculin by the Profession." It will be published with the subsequent discussion in an early issue of the journal.

CLINICAL NOTE.

THE TREATMENT OF RINGWORM.

By H. ALDERSMITH.

THE X-ray treatment of ringworm has raised a point of some historical interest. The value of the X-rays in the treatment of this disease depends on their depilatory action, and not to any destructive effect on the fungus.

At the Dermatological Section of the Annual Meeting of the British Medical Association in 1893 I used the following words: "For some time I have been convinced that ringworm is rarely eradicated by getting the so-called 'parasitocides' into contact with the fungus; but, while their use is essential to prevent the spread of the disease, yet, if such cases are to be cured, it is almost always by producing some alteration in the nutritive condition of the skin, so that the diseased hairs come out, leaving an '*artificial alopecia*,' or by causing irritation and exudation around and in the hair-follicles, so that the invaded hairs, together with the fungus, are thrown off, and a *temporary bare place is left*." I repeated this in the fourth edition of my book, and prophesied that some day an easier way of producing artificial Alopecia areata in the affected areas would be discovered than by the treatment I then employed—especially croton oil—and that in this way the disease would become more amenable to treatment, and not by the discovery of new parasitocides.

I think, in consequence, that at this time of the "*Entente cordiale*" our French colleagues would be willing to acknowledge to us a prior claim, at least with regard to the principle of the treatment. Nor have we failed to produce this temporary and artificial alopecia by simpler methods and prior to the use of X-rays. Besides the hundreds of cases where I have produced, and still do produce, temporary alopecia by croton oil, in a certain proportion of extensive cases of tinea a method I advocated years ago, viz., constantly soaking the parts with a saturated solution of boric acid in spirit and ether, has succeeded; and it was a case which has recently been under this treatment, and in which the treatment has been eminently successful, which suggested my again calling attention to the method.

Eleven weeks ago a case of tinea, with a number of patches (small spore) on the scalp, was seen by me in consultation, and I recommended the boric acid, ether, and spirit treatment, which was thoroughly carried out by Dr. Giffard. When the child was seen by me again a few days ago the hair had not only completely fallen out from all the diseased patches, but new, fine hair was commencing to grow all over them, and the ringworm was cured. Were this method only certain there would be no necessity of the X-ray treatment.

CURRENT LITERATURE.

A GENERAL CONCEPTION OF THE DISEASES OF THE SKIN.

BROCQ. (*Ann. de Derm. et de Syph.*, March, April, 1904.)

THIS is a notable attempt to mount to first causes for the explanation of many diseases which are at present difficult to class in well-defined groups, and to assign to hereditary and intra-uterine conditions the developments which take place in after-life. In this way a disease may be viewed as the resultant of two forces, the influences from without acting upon the special constitution of the individual; the theory of cutaneous reaction in individuals taking the place of a system of general diseases, of which the case in question forms an instance. The subject thus becomes infinitely complex; for the facts of heredity, state of health of the parents at the time of conception, moral and physical qualities of the mother during pregnancy, dietetic and other conditions of the infant—all take an important share in forming the individual factor which gives a special complexion to the disease when this occurs. Further, besides the hereditary and early influences, the individual acquires habits which may introduce modifications of his personality. The factor of the individual may therefore include (1) hereditary conditions; (2) conditions of the environment of the individual; (3) feeding; (4) general hygiene; (5) accidental injury, infection, etc., of which he may be the subject. The importance of this individual factor is strikingly exemplified by the experience of reaction to internal medication, of a supposed group of seven persons who may be given the same dose of potassium iodide, but with widely different results, according to the idiosyncrasy of each patient for the drug. Yet here the outside-acting force may be identical in composition and quantity, so that it must be said that each patient has his special "mode of reaction" or idiosyncrasy; and the same idiosyncrasy is obviously present in his relation to the other causes, besides medication, which may provoke eruptions. Thus the clinical disease urticaria may have as its provoking cause an innumerable list of articles of diet, a nervous origin, an emotional reflex, a parasitic affection, and so on. Thus two principles are deducible: (1) that the most various causes may produce the same eruption in different individuals; (2) an individual may react in the same way, as regards cutaneous disorders, to many diverse causes—*i. e.* the same eruption form may be produced by different causes in a predisposed

person. This idiosyncrasy may vary at different stages of his life, and the greatest confusion results from supposing these different reactions to be different diseases. The present state of our knowledge does not allow of our assigning essential causes to a number of these diseases which seem to depend upon the interaction of an unknown cause and the cutaneous reaction of the individual; in these cases the only means of distinguishing different types of reaction is by the objective character of the eruption; but this must be regarded as an unsatisfactory and provisional state of things, awaiting further elucidation. A "graphic" method of indicating the relations between these types of cutaneous reactions is proposed by Brocq, and a figure of fearsome complexity is actually supplied, rather unfortunately recalling the famous "Arbre des dermatoses," of Alibert. The paper is a most philosophical one and well worth study, but is exceedingly difficult to abstract.

E. G. L.

NERVOUS REACTION IN THE COURSE OF HERPES GENITALIS.

RAVAUT and DARRÉ. (*Ann. de Derm. et de Syph.*, June, 1904, p. 481.)

IN certain rare cases of Herpes genitalis, preceding nervous symptoms may be present of great intensity which appear to be immediately relieved by the outbreak of the eruption; they seem to point to an affection of the great root-trunks of the sacral plexus or the terminal fibres of the spinal cord. The pains are not limited to the site of the eruption, and often general constitutional symptoms accompany them. In another group of cases there are sensations of burning or itching, localised to the part on which vesicles will appear later. In a third class, which comprises by far the greatest number of cases, the subjective symptoms are slight, being confined to a moderate itching. The frequency of nervous associations with the eruption of Herpes genitalis led the author to make an experimental research into the nature of the cerebro-spinal fluid. Lumbar puncture was practised in twenty-six cases of genital herpes (seven men, nineteen women). The fluid was clear in all except one case, this being one accompanied by severe nervous symptoms. Details are given as to the cellular contents of the fluid, the bacteriological character (sterile in all the cases), the amount of albumen present, the results of inoculation into other animals (always negative), the effects of puncture in relieving symptoms, and the duration of the nervous phenomena in comparison with the character of the fluid. As a result of these researches the authors are convinced that all cases of Herpes genitalis accompanied by nervous symptoms are associated with modifications of the cerebrospinal fluid, and that these modifications are more definite according as the nervous phenomena are more pronounced.

A careful and detailed analysis is appended of twenty-seven cases in which the cerebro-spinal fluid was examined. The conclusions are interesting and suggestive.

E. G. L.

GENERALISED NEUROFIBROMATOSIS, WITH "MOLLUSCUM PENDULUM" OF THE RIGHT HALF OF THE FACE AND PTOSIS OF THE EAR. BÉNAKY. (*Ann. de Derm. et de Syph.*, November, 1904, p. 977.)

THIS was a curious case of Molluscum fibrosum involving the right external ear, which was greatly hypertrophied and displaced downwards, so that the

external auditory meatus was at the level of the angle of the jaw. The skin at the side of the face was thickened and thrown into deep folds, and in its substance were two tumours, one the size of a hazel-nut, the other as big as a hen's egg. The latter was tender to the touch, the former painless. The left side of the neck and the nucha were covered with small fibrous tumours and the rest of the body with similar tumours of various sizes. Upon the median and ulnar nerves on the right side were painful nodosities, and upon the right thigh, in the right popliteal space, on the right flank, and on the left arm, there were subcutaneous nodules, apparently in connection with peripheral nerves and excessively painful. There were besides very numerous pigmented naevi all over the body, and in fewer numbers, about fifty in all, vascular naevi, distributed chiefly on the trunk, and about the size of a lentil. Certain deformities of the cranium, vertebrae, and tibia were also present, with many symptoms of nervous derangement, but with no mental aberration.

E. G. L.

RADIO-THERAPEUTICS IN SKIN-DISEASES. BELOT. (*Ann. de Derm. et de Syph.*, May, June, July, 1904.)

THIS research emanates from the laboratory of Brocq, at the Broca-Paseal hospital. After some preliminary and useful observations on the theory of X-rays, the writer refers to some new methods of measurement of the quantity and quality of therapeutic effect exerted by a definite tube at any given time, since the same tube may vary much from time to time in the character of its emanations. If the vacuum in the tube is very high, the resistance is proportionately increased, and the penetration of the rays is greater, their absorption by the skin being diminished. Tubes in which the vacuum is very high are called hard tubes, and are not so well adapted for therapeutic effects as soft tubes, in which the resistance is less in proportion to the degree of the vacuum and the absorption of the rays by the skin is greater. Thus the resistance in the tube is a measure of the degree of vacuum obtained, and as this varies in the same tube, its estimation at any stated time becomes important. Bécélère has devised a means, the spinter-metre, of determining the internal resistance in terms of the length of the spark in atmospheric air.

The amount of the rays absorbed by the skin is measured by the colour changes which take place in certain pastilles manufactured for this purpose and known as the pastilles of Holz knecht. These are placed on the surface under the rays, and the colour compared with a standard scale divided into twelve units, called arbitrarily "H's." It is contended that no report of X-ray work is complete which does not include the following details: the source of the current, the length of the equivalent spark, the degree of radio-chromometry of the rays (measured by the radio-chromometer of Benoist), the distance of the tube from the lesion, the duration and number of the applications, and number of "H's" absorbed by the skin at each sitting.

Three methods of application of X-rays may be followed—(1) to give a daily dose of feeble activity for about five minutes, until the wished for quantity is reached, then to await the reaction; (2) to give the full dose desired in one sitting and to await the reaction; (3) to give the dose in two or three applications of medium intensity, with intervals of one or two days. Of all these, the third method is the best. The reaction generally takes from six to fourteen days to

appear, usually as an erythema, followed by some pigmentation. If the action has been too severe, vesication, ulceration, burns, accompanied by pain, may ensue. Any such reaction passing the limit of vesication is to be deplored.

As regards the source of energy, the authors consider static electricity to be preferable to that derived from an induction coil, as it damages the tubes less. The methods followed by Brocq are then described in great detail, for which readers are referred to the original paper.

The second chapter of this is devoted to the indications for radio-therapy. This has been applied in a very haphazard manner. Pusey, of Chicago, gives the following as biological effects produced by X-rays :

- (1) Atrophy of the skin and its annexes.
- (2) Destruction of microbes in living tissues.
- (3) Effect on metabolism of tissues.
- (4) Destruction of certain pathological tissues.
- (5) Anodyne action in certain tumours, in pruritus, and neuralgia.

It is objected that these results are entirely empirical, and a more logical method would be to note the known physiological effects of X-rays and to deduce from these the cases likely to benefit, controlling results with practical experience. In the review which follows of the diseases which have been found to benefit by this author personally no system is observed, and it is impossible to abstract the results which are noted in the case of tinea, favus, acne, psoriasis, lupus, mycosis fungoides, sarcoma, and many other diseases. The paper forms a valuable source of reference to the work done by many observers, as well as by the authors themselves, in elucidating the effects of X-rays on many skin-diseases. The bibliography alone occupies eleven closely-printed pages, and has been carefully compiled, except that some striking English cases have been overlooked, notably in Mycosis fungoides.

E. G. L.

THE TOXIC AND IMMUNISING SUBSTANCES IN SYPHILIS.

HALLOPEAU. (*Ann. de Derm. et de Syph.*, August, September, 1904, p. 737.)

THIS is a paper which was read at the fifth Congress of Dermatology, held in Berlin last year. The conclusions of a somewhat diffuse article may be summarised as follows : The toxins of syphilis, although they may be justly described in the words of Neumann as "the unknown products of an unknown microbe," must necessarily take a part in the symptoms of syphilis, and are worthy of study. It is probable that these toxins are different in character at different stages of the disease. There is no pathogenic toxine evolved during the primary stage, *i. e.* between inoculation and the development of the chancre, but there must be some protective substances of the nature of vaccines developed during this stage, since syphilis cannot be acquired during this time. The action of the toxins may be localised to the immediate vicinity of the infective focus, or it may be generalised, this action being exemplified in the development of lesions and glandular enlargements, both local and general, as well as by the immunity to fresh infection. The ascription of the symptoms of the later stages to toxins alone must be accounted mistaken, and similarly the transmission of syphilis cannot be explained by the action of the toxins alone, without the microbe. The law of Colles must be explained by the hypothesis that vaccinal substances produced by the infected embryo pass into the blood of the mother by the placental circulation, and

similarly an infected mother may confer immunity upon her offspring for a period, which diminishes in effect progressively after birth; such offspring, if contracting syphilis later, will have it in a modified form. But although an organism tainted with syphilis is immune to recontraction of the disease from without, fresh developments of syphilis by proliferation of the microbe within the organism ("intra-inoculations") may take place; but these fresh developments as a rule respect the surfaces of the skin already attacked by earlier lesions. The theories of Metchnikoff are adduced by which cells called "macrophages" are supposed to develop in these areas and to destroy the infective bacilli, and so oppose re-infection. The serum-therapeutics of syphilis are still too doubtful to be practical forms of treatment, but new light may be confidently anticipated as a result of the inoculation experiments upon anthropoid apes.

E.G.L.

ON CUTANEOUS BLASTOMYCOSIS. DUBREUILH. (*Ann. de Derm. et de Syph.*, October, 1904, p. 865.)

THIS is a communication which was made to the Fifth Congress of Dermatology, held in Berlin last year. The case upon which Dubreuilh bases his paper occurred in a native of Poitiers, who had never quitted France, and indeed had not travelled far from his birthplace. There was no family history of tuberculosis, and no personal symptoms of that disease. His occupation was to chop wood derived from old railway sleepers, mostly of solid oak. The disease was in the form of a patch on the back of the right hand, the first symptom having been the appearance of a greyish tumour in this position six years previously. This had been slightly itchy from time to time, and had cracked and suppurated occasionally. It had been twice scraped, and this treatment had resulted in the formation of a scar in a part of the lesion. When seen by Dubreuilh the patch was 5 centimetres in its longest diameter, and was irregularly circinate; it was raised about half a centimetre, with an oblique edge and a hob-nailed surface, covered with epidermic scales. There was no ulceration. The colour of the patch was a dark red, almost violaceous; it was firm but not hard to the touch; it was movable in the deeper tissues; the surrounding skin was normal. The entire patch was removed under chloroform, and the wound subsequently skin-grafted. A very detailed description of the histology is given. The tumour appeared lobulated, the lobules being formed in part by epidermic prolongations, partly by connective-tissue (fibrous) trabeculae. The cell-infiltrations which formed the greater part of the lobules consisted of mononuclear lymphocytes, and spindle-cells, and plasma-cells, and very large and numerous giant-cells, Dubreuilh counting 120 in a single section; a third of these giant-cells contained blastomyces, with occasional central miliary abscesses. The blastomyces found was a round body, 10 to 12 μ in diameter, with an outer thick membrane which was brown in unstained sections treated with caustic potash. This remained brown in preparations stained with hæmatein-eosin, or cochenille-eosin, but took a deep blue with polychrome blue or with thionine. Within this outer zone there was a second, moderately thick, but clear and transparent, and unstained. The central portion was not clear, being granular, but without taking the stains used. Reproduction seemed to be by fission, not by budding. These bodies were uniformly distributed either within the giant-cells or amongst the masses of epithelioid cells. The specimens were submitted for an opinion to Gilchrist, who

confirmed their identity with those with which he was familiar. They were peculiar in the method of reproduction by fission, not by budding, and in the number found in the sections, as well as in their position with regard to the cellular collections. It is probable that these differences represent different species of a similar organism, much as is the case with the different types of trichophytous.

This constitutes the fourth case observed in Europe (if Sequeira's case was an undoubted example) and the first seen in France. It is not surprising, therefore, considering this rarity, that Dubreuilh's earlier diagnosis was that of tuberculo-sis cutis, to which the clinical aspect of the patch bore an extremely close resemblance.

E. G. L.

ALOPECIA DUE TO ACETATE OF THALLIUM. V. L. CARLO. (*Giorn. Ital. d. Mal. Ven. e della Pelle*, fasc. i, 1905.)

THE salt was injected into cats and was applied externally in vaseline and traumaticine both in the strength of 1 in 6. This caused shedding of their eye-lashes and eyebrows and set up conjunctivitis and keratitis, followed by staggering gait, convulsions, ending in death from malnutrition. The only visceral lesion observed was congestion of the kidneys, the medulla being specially affected.

The shed hairs were soft and fragile with scarcely any bulb visible, the medulla and cortex appearing normal. No change was detected in the arrectores pili or in the sebaceous glands, although alteration in their function may have occurred. There was an excess of mast-cells in the skin. Some follicles had hairs broken at or near the surface of the skin, while some were empty. The bulbs of some hairs about to fall were "full" with the papillæ more or less atrophied. Others were "hollow" with keratosed cells which were continuous externally with the outer root-sheath. Above the atrophied bulbs the epithelial cells ceased, and the medulla was absent.

New hairs started from hairs with full bulbs. Prolongations from the external root-sheath budded out and were connected with the new hairs by embryonic nucleated cells. Some follicles were blocked by corneous cells, pigmented remains of fallen hairs, and fragments of hairs vertically split. The loose hairs with full bulbs might be transversely broken at or near the surface of the skin, and above the bulb longitudinal fissures could be seen.

Transverse sections did not show any distinct medulla, and the cortex was more frequently seen and was much thinner than usual. Around the bald patches resulting from local applications, some hairs were shed, others were loose, and having full bulbs were unaffected in colour and consistency. A part of the untreated skin was shaved, and it was observed that the hair grew as much in six days as on the bald patches in twenty-seven. Slight painting of the skin with the drug caused mild dermatitis, with erythema and a few vesicles, which was followed by a mild desquamation. There was some slight perivascular infiltration in the corium and some cell infiltration of the epidermis resulting in keratosis.

From these observations it was concluded that acetate of thallium acted as a neurotrophic poison especially affecting the hair-follicles.

T. P. B.

AN INQUIRY INTO THE ETIOLOGY AND NATURE OF THE TOXIC ERYTHEMATA. JAY F. SCHAMBERG. (*Journ. Cut. Dis.*, including *Syph.*, October, 1904.)

In a paper read before the American Dermatological Association the author

concludes that nearly all cases of scarlatinoid erythema, morbilliform erythema, Erythema multiforme, Erythema nodosum, urticaria, and purpura are the result of the circulation in the blood of chemical poisons. He suggests the following classification: (1) Bacterial and protozoal toxins; (2) ptomaines; (3) leucomaines and other metabolic poisons; (4) drugs. At first sight, he says, there would appear to be an exception to this generalisation in the urticarias of nervous origin; but on closer scrutiny it seems quite possible that these may be due to metabolic poisons elaborated in the system as a result of faulty innervation.

T. C. F.

PINTA: PANO BLANCO. PAUL G. WOOLLEY. (*Journ. Cut. Dis., including Syph.*, October, 1904.)

Dr. G. WOOLLEY reports from Manilla the case of a Filipino boy, who exhibited slowly-spreading pinkish-white patches, irregular in size and shape, on the ankles, dorsa of feet, shins, knees, elbows, hands, wrists, and one on the right shoulder. The larger patches were roughened and somewhat infiltrated. There was very slight scaling and some itching. In scrapings mycelial filaments, usually, long and terminating in a bunch of spores, were found (? penicillium). The author identifies this affection with pinta, and refers to somewhat similar cases recorded by Legram in North Africa, and by Sandwith in Egypt. He says the clear white colour of the irregular patches, the presence of sensation, and of itching, with the microscopical findings, are enough to insure a correct diagnosis. Trichophytic diseases are extremely common in Manilla.

T. C. F.

ON SENILE TRUE HYPERPLASTIC SEBACEOUS GLAND TUMOURS, ESPECIALLY OF THE FACE. HIRSCHFELD. (*Archiv f. Derm. u. Syph.*, October, 1904, lxxii., p. 25.)

THIS contribution is based on a clinical and histological examination of a series of cases of sebaceous gland tumours in adults over 40 years of age, which occurred in the clinic of Professor Jadassohn at Berne. The forehead was the usual site for the lesions to occur, though occasionally the cheeks and nose were affected. The tumours varied in size from that of a pin's head to a linseed; they were slightly raised and flat on the surface, in shape they were irregularly round or polygonal, and in colour they were whitish-yellow, or light brown. A few of them showed a central depression corresponding to the opening of a dilated sebaceous duct, and through this sebum could be expressed. They did not tend to disappear spontaneously or on pressure. There was no itching associated with their presence. In some respects they suggested adenomata sebacea, but differed from them in that they only occurred in individuals over 40 and had a different distribution. A histological examination of various sections of tumours from four patients showed a similar structure throughout. The tumour consisted of a mass of sebaceous glands which were normal in structure but presented widened ducts, which either opened into the funnel of a lanugo hair-follicle or on the surface of the skin. The elastic tissue in the neighbourhood of the glandular mass was degenerated. In the dilated sebaceous ducts *acari folliculorum* were detected, and these were excellently stained by acid orcein and by Weigert's stain for elastin. The author believed that the tumours were congenital in origin and belonged to the group of naevi, but suggested the possibility of the hyperplasia being the result of irritation such as

might be produced by the acari. The literature on the subject is discussed in the paper. (This observation is not a new one. Radcliffe-Crocker described the affection, with a microscopical drawing of it, under the heading of "Hypertrophy of the Sebaceous Glands," in Vol. II, p. 1063, of his text-book.) J. M. H. M.

ON THE TECHNIQUE OF INTRA-MUSCULAR INJECTIONS,
GROSZ. (*Archiv f. Derm. u. Syph.*, October, 1904, lxxii, p. 65.)

THIS communication is mainly occupied in a discussion on the situations where intra-muscular injections may be done without injuring underlying structures, such as nerves or blood-vessels. The gluteal region is the site generally chosen, but there are portions of it where the ischiatic nerve may be injured and Neisser reported a case where a neuritis of the nerve resulted from injury caused by an injection-needle. Branches of the inferior gluteal artery may also be punctured. According to the writer, the following triangle should be mapped out and injections should be done either on its sides or in the area of skin enclosed by it. The three points of the triangle are as follows: Point 1 is situated on a horizontal line between the great trochanters of the femora, and is midway between the great trochanter and the tuberosity of the ischium. Point 2 lies in a line vertical to the above line, and is midway between point 1 and a horizontal line drawn across the back at the level of the anterior iliac spine. Point 3 is on the same level as Point 2, but nearer the middle line, and is situated midway between the great trochanter and the anal fissure. According to Möller, injections may be safely done in the gluteal region anywhere above a horizontal line at the level of the upper process of the great trochanter of the femur. J. M. H. M.

ON LUPUS PERNIO. KARL KREIBICH. (*Archiv f. Derm. u. Syph.*, August, 1904, p. 3. Five plates.)

THIS disease, originally described by Besnier in 1888, was believed by him to be a variant of Lupus erythematosus. Subsequent observations on it by Jarisch, Tenmeson, and others lead Jarisch to regard it as a form of tuberculosis of the skin associated with venous stasis. There is still some difference of opinion as to its true nature.

In this contribution Professor Kreibich describes in detail three typical cases of the disease. The first occurred in a male, aged 35 years, a printer by trade, and the disease began in his feet and hands and subsequently attacked his nose, cheek, left ear, and gluteal regions. The second case was that of a woman, aged 50 years, and the nose, cheeks, and extensor aspects of the upper and lower extremities were involved. In the third case a man aged 56 years was affected, and it began on the back of his left hand and spread later on to the nose, upper lip, left cheek, and ear. A critical survey of the literature, including these three cases, shows that the disease most frequently attacks the nose, the next most common situation being the hands and ears. The venous stasis, which is most probably the result of cold and appears naturally in situations where the peripheral circulation is feeblest, is regarded as preceding and predisposing to this disease. The primary lesion is a sharply defined red or bluish-red raised macule which quickly spreads. This on pressure with a diascopie presents either a diffuse yellowish-red tinge or shows deep-seated yellowish-brown foci of infiltration. There is, as a rule, no tendency to ulceration, necrosis, and atrophic scarring, such as occur in Erythema induratum, though scarring may occasionally be present. The skin over

the tumour is usually smooth. When the hands or feet are affected the joints and even the bones become swollen and thickened. This is shown in a skiagraph of the hands in Case I. The histological characteristics are defined foci of cellular infiltration made up chiefly of round cells and epithelioid cells. Giant-cells were few or absent. The foci differed from those of nodular lupus in being vascular throughout and showing no evidences of degenerative processes or necrosis in the centre. They were situated as a rule deeply, near the subcutaneous tissue. The blood-vessels, especially those of the sub-papillary plexus, were dilated and surrounded by foci of cellular infiltration.

No tubercle bacilli have been detected, nor have injections of tuberculin given a positive local reaction. The disease does not tend to attack the mucous membranes as *Lupus vulgaris* naturally does.

Lupus pernio thus presents several definite points of distinction from *Lupus vulgaris* and from *Erythema induratum*, and according to the writer it has not yet been definitely established as a tuberculous manifestation. J. M. H. M.

CONTRIBUTION ON THE QUESTION OF THE CAPABILITY OF ABSORPTION OF THE INTACT SKIN. SUNDUROW. (*Archiv f. Derm. u. Syph.*, August, 1904, p. 16.)

THE vexed question of whether the intact skin is capable of absorbing medicaments in solution or in ointments has been discussed and experimented upon for the best part of a century, and is far from being settled yet. That the intact skin is capable of absorbing certain substances, such as mercury when incorporated in an ointment, is now generally recognised, but that there are a large number of substances which have not the power of passing through the epidermis seems equally certain. The negative results recorded in this paper bear this out. The experiments were carried out in the pharmacological laboratory of Professor Burginsky, at Tomsk. A number of dogs as well as men were experimented upon. The back of a dog was shaved and washed with a 5 per cent. solution of soda, and various medicaments were rubbed in for ten minutes. A fistula was made into the bladder and the urine tested for the active ingredient in the lotion or ointment rubbed in. Where man was employed in the experiments the preparations were rubbed into the inner surface of the upper arm, and the urine examined. Salicylic acid was one of the principal drugs used in these experiments, and it was dissolved in alcohol, ether, or chloroform, and then incorporated with one or other of the following fats—lanoline, vaseline, and pigs' fat. After a large number of experiments had been performed, the following conclusions were arrived at.

Of the various medicaments experimented with the majority were not absorbed by the intact skin. Among those that were absorbed were salicylic acid and aconite, and this fact was believed to be the result of a physiological action of the skin and not to be a mechanical effect.

The experiments in which lanoline was employed as a base gave disappointing results, and the writer does not consider it to be an agent which can be depended on to allow the absorption of a drug incorporated with it to take place. The washing with soda, and the rubbing, did not cause any increase in the absorptive capacity of the skin.

This paper contains a detailed survey of the literature on the subject.

J. M. H. M.

THE BRITISH JOURNAL OF DERMATOLOGY.

AUGUST, 1905.

THE INFLUENCE OF POTASSIUM IODIDE ON THE RESISTANCE OF THE BLOOD FLUIDS TO STAPHYLOCOCCUS ALBUS.

By G. T. WESTERN, M.A., M.B. Camb.

THE frequent appearance in iodism of a pustular eruption over the body and limbs has suggested that this may possibly be explained, either by some influence of this drug over the serum, such as a limitation of its power to produce those bodies which prepare the bacteria for phagocytosis, or a power of combining with or neutralising those bodies when formed.

In support of this idea is the fact, recently demonstrated, that "Opsonins," like "Complements," may be neutralised or bound by various salt solutions (CaCl_2 , BaCl_2 , SrCl_2 , MgCl_2 , K_2SO_4 , NaHCO_3 , $\text{Na}_3\text{C}_6\text{H}_5\text{O}_7$, $\text{Na}_2\text{C}_2\text{O}_4$, $\text{K}_4\text{Fe}(\text{CN})_6$, and other substances, *e. g.* formaline), so that they cannot act upon bacteria (1).

The experiments which I have carried out in order to ascertain whether this idea can be supported by laboratory investigation may be divided into two main groups:

(a) Those carried out with the blood of patients before and during a period in which they were placed under the influence of potassium iodide.

(b) Those carried out by adding *in vitro* to the serum of a normal man isotonic solutions of this salt.

Before detailing the experiments some evidence of the action of the blood on staphylococcus cultures will be mentioned.

Since the discovery of the white blood corpuscles a large mass of work has been done on them, and they have been shown to play an important part both in health and disease.

Metchnikoff, at the head of one school of thought, has for many years attempted to prove that to the leucocyte falls the chief share in the never-ceasing fight against micro-organisms, and that it is by an elaboration of these white cells that the host is enabled to overcome the many microbial diseases. Further, he has attempted to show that the ultimate destruction of these invading micro-organisms is brought about in the interior of the leucocyte by a process of digestion assisted by ferments, which ferments are elaborated within the cells for this purpose.

In opposition to this view, Buchner has maintained that the defence against the pathogenic virus is to be found in the humours or fluids of the body, and that the work of the leucocyte is subsidiary to this.

This subject has been worked out recently in a simple and convincing series of experiments by Professor A. E. Wright, in conjunction with several other bacteriologists.

Experiments to estimate the inhibitory power exerted by the serum on the growth of a staphylococcus culture have been carried out as follows (2) :

Comparative counts were made of the number of staphylococcus colonies which developed in a series of measured volumes of gelatine cultures, mixed—

(a) With sterile broth.

(b) With serum derived from normal men.

(c) With serum derived from patients suffering from staphylococcus infections.

Only inconstant and very inconsiderable differences were found between the number of colonies developing in the tubes filled with the different mixtures particularised above.

Experiments with dilutions of staphylococcus 100- to 10,000,000-fold, which were digested both with normal and with immunised serum, show no inhibitory action.

The conclusions that must be arrived at from these experiments are therefore :

(a) Normal serum has no inhibitory action on cultures of staphylococcus.

(b) That inoculation with sterilised cultures of staphylococcus does not confer upon the serum any inhibitory property against staphylococcus cultures.

Turning to phagocytosis, means have been devised for estimating the "phagocytic" index of the blood as a measure of the resistance of that blood to infection (3).

By a study of serum and phagocytes separately, it has been shown that in so-called phagocytosis a most important, if not a cardinal, part is played by substances in the serum, which substances have nothing to do with Buchner's alexins (4).

The phagocytes are obtained free from serum by drawing blood into a 1 per cent. solution of sodium citrate in 0.85 per cent. sodium chloride. This prevents clotting, and after centrifugalisation the plasma and salt solution can be removed with a pipette, and the corpuscles freed from any remaining traces of plasma by repeated washings in normal saline solution (0.85 per cent.).

Serum is obtained by allowing blood to clot in a capsule and separating with a centrifuge.

If now some washed corpuscles be mixed with a portion of a culture of staphylococcus, no phagocytosis takes place. If, however, some serum be added, phagocytosis can again be observed.

The serum may, therefore, be said either to stimulate the leucocytes to perform the part of phagocytes, or to alter the bacteria in some way which makes phagocytosis possible.

To ascertain which of the above functions the serum performed the following experiments were carried out:

(1) Three volumes of washed corpuscles were mixed with three volumes of serum and digested for fifteen minutes at a temperature of 37°C . This mixture was then heated to 60°C ., as at this temperature it was shown that the power of the serum is destroyed. On cooling, one volume of an emulsion of a culture of staphylococcus was added and the whole incubated for fifteen minutes at 37°C . A film was then made and it was shown that little or no phagocytosis had taken place.

(2) Three volumes of serum were mixed with one volume of staphylococcus emulsion and incubated at 37°C . for fifteen minutes. This

was then heated to 60° C., and when cool was mixed with three volumes of washed corpuscles. After again incubating for fifteen minutes, films were made which, on examination, showed that marked phagocytosis had taken place.

The conclusion to be drawn from these two experiments is, that the action of the serum is mainly a modification of the bacteria which renders them a ready prey to the phagocytes.

To the bodies which bring about this modification Professor Wright has given the name "Opsonins."

Whether the serum also contains "Stimulins" for the phagocytes is as yet unproved.

Thus the action of the blood on a culture of staphylococcus is twofold:

(a) A modification of the microbe by means of the "Opsonins" in the plasma.

(b) Ingestion of the modified bacteria by the leucocytes.

The leucocyte is practically an indifferent factor when the phagocytic power of different bloods is compared (5). The power of the serum to modify bacteria in this way, compared with the power of the serum of a normal healthy man, is termed its "Opsonic Index."

This Opsonic Index has been shown to be a constant factor in health, with the exception that in women it is markedly lowered during menstruation (6). In disease, however, very remarkable variations have been shown to occur.

Professor Wright has shown that in general staphylococcus infections there is a well-marked lowering of the phagocytic power and Opsonic Index to staphylococcus (7).

Dr. Bulloch has shown a similar lowering of the Index to the tubercle bacillus to be commonly associated with tuberculous infection of the skin (8).

The questions which we have to answer are therefore:

(a) Does the administration of potassium iodide produce a fall in the Opsonic Index to staphylococcus?

(b) Has a person, who is suffering from a pustular iodide eruption, an abnormally low Opsonic Index? and does such a person's index rise when the administration of iodide is discontinued and when the eruption subsides?

The cases and experiments recorded below serve to answer these questions.

In the following cases I have assumed my own serum to have a normal and constant Opsonic Index, and on this basis I have calculated the indices of others, treating my own as unity.

I have in all cases used serum in the place of plasma, as it has been shown to have identical power (9).

The corpuscles I have used have in every case been from my own blood, drawn into a solution of sodium citrate 1 per cent., and sodium chloride 0.85 per cent. After separating with the centrifuge they have been washed in a relatively large volume of sodium chloride, 0.85 per cent.

The emulsion of staphylococcus used has been prepared from a 20-24-hour culture of *Staphylococcus albus*, grown on a slanting broth-agar medium at 37° C. A small quantity of sterile salt solution (0.85 per cent.) has been used to wash off the culture; this is then placed in the centrifuge for about one minute to allow any masses to fall to the bottom. The supernatant fluid is then used as the emulsion.

The dilution has in all cases been as follows:

Serum	.	.	.	.	.	.	three parts.
Emulsion	.	.	.	.	.	.	one part.
Corpuscles	.	.	.	.	.	.	three parts.

In all cases twenty-five polymorphonuclear leucocytes have been counted.

Series of Cases.

(1) Albert H—, aged 42 years. On first coming under observation was suffering from *eczema and gummatous thickening* of the skin, and his Opsonic Index was 94. He was given a mixture containing potassium iodide, grs. x, *t.d.s.* He was also ordered to cease taking alcohol.

At the end of one week his Index rose to normal and remained so as long as he was kept under observation, and his eruption gradually cleared up.

The slight rise at the commencement may perhaps be attributed to the absence of alcohol in a man who was accustomed to a liberal allowance, but the alteration is insufficient to lay any great stress on.

The total amount of potassium iodide taken in twenty-one days was 630 grains.

(2) Lottie K—, aged 25 years. Came to the hospital suffering with *tertiary syphilitic ulceration of the nose*.

She was treated with potassium iodide, grs. x, *t.d.s.* Her Opsonic Index, however, showed no marked variation.

The total amount of potassium iodide taken in fourteen days was 420 grains.

(3) Amy H—, aged 53 years. Has had recurrent *cutaneous gummata* for several years. She had had no potassium iodide for four months previous to the time when these observations were made.

On January 26th her Index was '92; she was then given potassium iodide grs. x, *t.d.s.* There was a slight fall during the next week, but in a fortnight the Index was again up to '93.

The total amount of potassium iodide taken in twenty-one days was 630 grains.

(4) Eliza H—, aged 49 years. This patient came to the hospital on January 5th, suffering from *hyperkeratosis* and *cutaneous gummata*. She was treated for three weeks with a mixture containing potassium iodide, grs. x, *t.d.s.* She then showed a slight pustular eruption. Her Opsonic Index was estimated and found to be '864. The iodide was therefore reduced to grs. v, *t.d.s.*, and in fourteen days the rash cleared up. Her Opsonic Index, however, showed no alteration.

The total iodide taken in the three weeks previous to coming under observation was 630 grains. That taken during the twenty-one days her Opsonic Index was estimated amounted to 315 grains.

(5) Isaac W—, aged 39 years. Had had *syphilis* seven years ago, and on coming under observation had *Tubes dorsalis*.

His Opsonic Index before treatment was '98. A mixture containing potassium iodide, grs. xv, *t.d.s.*, caused no alteration.

The total amount of potassium iodide taken during the twenty-one days was 945 grains.

(6) Charles N—, aged 42 years. Came to the hospital suffering with *osteo-arthritis*.

He was treated with potassium iodide, grs. x, *t.d.s.* His Opsonic Index, however, showed no variation.

The total amount of potassium iodide taken in the twenty-one days was 630 grains.

(7) Horace A—, aged 34 years. Has had extensive *psoriasis* for many years.

On testing his Opsonic Index it was shown to be 1'02.

A mixture containing potassium iodide, grs. v, *t.d.s.*, was given, the dose being doubled at the end of a fortnight. His Index, however, at no time showed any marked variation.

The amount of potassium iodide taken in the first fourteen days was 210 grains; that taken in the last seven days was also 210 grains.

(8) Ellen Y—, aged 35 years. Has suffered several years with *psoriasis*.

She was treated with potassium iodide, grs. x, *t.d.s.*, without any alteration in her Opsonic Index being observed.

The total amount of potassium iodide taken in the fourteen days was 420 grains.

(9) Richard B—, aged 38 years. Was admitted suffering from a *paresis* of unknown origin, affecting one arm.

His Opsonic Index was '81.

He was given a mixture containing potassium iodide, grs. x, *t.d.s.* This was after eight days increased to grs. xv, *t.d.s.* His Opsonic Index, however, showed no marked variation.

The potassium iodide taken in the first eight days amounted to 240 grains, that taken in the following twenty-four days to 1080 grains.

(10) Sidney A—, aged 26 years, gave a history of having suffered with *facial acne* for ten years. For the last four months he had been treated with potassium iodide. As a result of this treatment he had developed an extensive pustular eruption, which was especially severe on the back.

His Index was estimated and found to be '8.

He was treated with liquor arsenicalis. *℥iij, t.d.s.*, an ointment being applied locally.

At the end of four weeks the eruption had entirely disappeared; his Index during that time showed no variation.

The persistently low Index shown in this case was no doubt due to the chronic acne from which he suffered.

The following experiment was carried out to ascertain whether the presence of potassium iodide in the serum, *in vitro*, has any influence on the opsonic power of that serum.

A measured quantity of serum was taken and diluted with four times its volume of an isotonic solution of potassium iodide, thus making a one-in-five dilution (10).

A sample of citrated blood was taken, and after centrifugalisation and removal of the supernatant citrated plasma, the remaining corpuscles were washed well in an isotonic solution of potassium iodide, the latter being separated again by the centrifuge.

A twenty-four hour culture of *Staphylococcus albus* was taken, and an emulsion prepared in 0·85 per cent. sodium chloride as described above.

The following parts of each of the above preparations were then taken :

Diluted serum	.	.	.	.	3 parts
Washed corpuscles	.	.	.	.	3 parts
Culture emulsion	.	.	.	.	1 part

These were thoroughly mixed together, and then incubated for fifteen minutes at 37° C. Films were then prepared and stained with Leishman's stain. A leucocytic count gave the following result :

						Average
Tube 1,	25 polymorphonuclear leucocytes	contained	401 cocci	=	16·04	
„ 2,	25 „ „ „		413 „	=	16·52	
„ 3,	25 „ „ „		382 „	=	15·28	

As a control for the above, the following was carried out: One part of serum was diluted with four parts of 0·85 per cent. sodium chloride.

A sample of citrated blood was taken and after centrifugalisation

the deposited corpuscles were washed with isotonic sodium chloride instead of potassium iodide. The same emulsion as above was used.

The following parts of each were then taken :

Diluted serum	.	.	.	.	3 parts
Washed corpuscles	.	.	.	.	3 parts
Culture emulsion	.	.	.	.	1 part

These were treated as above, the counts giving the following figures :

					Average
Tube 1, 25 polymorphonuclear leucocytes contained 383 cocci	=	15.32			
„ 2, 25	„	„	„	384	„ = 15.36
„ 3, 25	„	„	„	397	„ = 15.88

Taking, then, the index of the control serum as unity, that of the serum diluted with potassium iodide will be $\frac{11.96}{11.64} = 1.027$.

Conclusions.

The conclusions to be drawn from the above series of cases and experiments are as follows :

- (1) The administration of potassium iodide has no influence on the Opsonic Index of the serum.
- (2) An iodide eruption is not necessarily associated with a low opsonic index.
- (3) The addition of potassium iodide to serum, *in vitro*, does not interfere with its opsonic power.

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AN INQUIRY INTO THE ÆTIOLOGY OF INFANTILE
ECZEMA.

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(Concluded from page 263.)

SECTION IV.—CONCLUSIONS.

SYNOPSIS OF CONTENTS.

Review and criticism of various theories as to the causation of infantile eczema.
The "digestive disturbance" theory.
The "external irritation" theory.
Characteristics of Traumatic eczema.
The external irritants of infancy.
The neuro-cutaneous system of infants.
Eczema as a (? protective) cutaneous reaction.

THE various theories as to the causation of infantile eczema, which have been held during the last century, may be broadly divided into three groups. In the first place there is the theory of digestive disturbance, with its various sub-divisions; secondly, the theory of external irritation; and, thirdly, a group composed of all the remaining theories—vaccination, dentition, diathesis, etc.

Undoubtedly, the weight of opinion, judged by numbers alone, is in favour of the first of these; but, as I have shown previously, there is considerable division amongst those who hold it, as to the exact nature of the digestive disturbance in question.

The second theory also is variously interpreted by different writers. Hebra, its greatest supporter, thinks the irritants may be almost innumerable, whilst others, amongst whom Unna, by his brilliant work during recent years, stands out pre-eminent, lay stress on one particular form of irritant, namely, micro-organisms. Finally, there is the modern school, headed by Brocq, which denies the micro-organism as cause, and leans towards a modification of the teaching of Hebra.

It may be added that many writers combine the two theories of digestive disturbance and external irritation in various proportions.

On the various divisions which make up the third group it is hardly

worth while to spend much time. A reference to my statistics shows clearly, that neither dentition, nor vaccination, can possibly be the cause in most cases; and as the three events, dentition, vaccination, and infantile eczema, all occur during the first half-year of life, it must frequently happen that they alter the order of their occurrence, and that, as a result, remarkable coincidences often take place. Nor does my evidence give any strong support to an inherited diathesis, in the loose sense in which that term is usually used.

I propose, therefore, to devote the remainder of this section to the consideration of the first two of these groups.

We have two questions before us—Is infantile eczema set up by disorder in the digestive apparatus, either directly or indirectly, either in the alimentary canal or in the tissue metabolism? Or, is it set up by local external irritants acting directly on the skin itself?—it being granted, that, in either case, the various parts of the nervous system in connection with the tissues affected may be involved.

Basing my statements upon the examination of these sixty cases, I am of opinion that the evidence is insufficient to support the theory of digestive disturbance or malassimilation as the cause of eczema; that, on the contrary, there is a considerable weight of evidence, as regards the digestive system, which is strongly opposed to such a theory. My reasons for these conclusions are as follows:

(a) In most of the cases there is no history of any other symptom of digestive disturbance having preceded or accompanied the first appearance of the eruption.

(b) Most of the cases have shown no symptoms of digestive disturbance during the whole of the period during which the eruption has lasted.

(c) Neither rickets or malnutrition was present in any considerable number of cases.

(d) Most of the cases were breast-fed at the time of the first appearance of the eruption. Several were breast-fed *alone*; others had an occasional biscuit or other food in addition. Only a small percentage were bottle-fed entirely.

(e) In most of the cases the same mother had suckled previous children under similar conditions, none of whom suffered from eczema.

(f) There is no evidence of excessively frequent child-bearing, over-suckling, or illness of the mother.

(g) Only a very small percentage of the whole number of cases occurred during the three summer months, the period during which infantile gastro-intestinal disturbances are by far the most common.

I would also add a few general observations bearing upon this subject. If digestive disturbance is the cause, why does the eczema continue long after all the digestive disturbance has been regulated or removed? Why is it that infantile eczema of the ordinary type does not begin, more often, at the stage of weaning, when far more irregularities of diet occur than during the first three months of life? How does the "digestive disturbance" theory explain the fact that severe generalised recurrences of the disease appear after the infant rubs itself, even though there be no change whatever in the diet at the time?

Having thus dealt with the first theory, I shall attempt to show what evidence an analysis of these cases gives for or against the second theory, that of external irritation.

And I may here state that I am unable to deny, from personal investigations, the presence of a constant pathogenic organism in all these cases, but that I think it rests with those who support the parasitic theory to demonstrate such, in accordance with the laws of bacteriology. Hitherto the constant presence of such a pathogenic organism in cases of eczema has not, in my opinion, been satisfactorily demonstrated. And even if it were, I am unable to understand how it alone could satisfactorily explain all the features of an infantile eczema. Certainly not, if we are to suppose that every vesicle, every papule, every patch, of erythema occurring in such cases, is due to local parasitic agency.

What, then, is the evidence in favour of external irritation? It may be stated briefly as follows:

1. In almost every case the eruption commences on some part of the head or face. In the infant, during the first few weeks of life, this is practically the only exposed part, at any rate when out of doors.

N.B.—In the adult the head is never, and the face but rarely, the initial site of eczema.

2. The secondary distal eruptions on other parts are, in most cases, of much less severity, and tend to disappear directly the original sites recover, unless they (the former) are irritated.

3. The comparatively constant age at which the eruption appears, about the time when the infant is first released from the more extreme protection which it has received during the first few weeks of life.

4. The greatly increased percentage of cases which begin in the colder months of the year, varying markedly with the temperature changes in each quarter, and particularly indicating an increase in number where there is a sudden decrease of temperature.

In addition to these statements based on my statistics, I hope to show later that there are other considerations which support this theory of external irritation. Before doing so, however, I think it is necessary to state that eczema from external irritants is no novel idea: many examples of it in adults are all too familiar, such as washerwoman's eczema, grocer's itch, etc. Many other forms of traumatic eczema also occur, some of which are, perhaps, less commonly recognised as such.

In order to make clear my views as to the *modus operandi* of the external irritant, it is essential to study the characteristics of these so-called "traumatic eczemas." *

Cases of traumatic eczema present certain general features, which I have attempted to sum up as follows:

1. The irritant must not be too strong, so as to produce too marked a local inflammation.

2. It must be repeatedly applied, often for a considerable period before any general reaction occurs. This, however, varies in different persons.

3. The effect appears first on that part of the surface which has been more directly in contact with the irritant.

4. This primary local eruption may, for some time, be the only part affected.

5. Sometimes a corresponding area on the opposite side of the body may be partially or wholly affected, soon after the appearance of the primary eruption; it is usually less severe.

N.B.—This is most noticeable in the upper extremity and face, less so in the lower extremity, least in the trunk.

* I shall use the term "traumatic eczema" throughout, meaning thereby to include all those cases in which eczema occurs from any external irritant, whether used in occupation, as therapeutic agent or otherwise.

6. If the irritation is continued in the same way, and *limited to the original situations*, other distant parts of the skin gradually or suddenly become affected, the intervening skin being, apparently, normal.

N.B.—These distal eruptions are, in almost all cases, symmetrical, and appear at parts of the body which we know as the common sites of eczema. They are much less severe than the eruption on the primary site. They may persist for a long time after the original irritant has been removed. They are even more readily reproduced than before by a repetition of the original stimulus.

7. After a time the reaction is capable of being produced or kept up by other, and less powerful, irritants than that which first produced it.

The following case, which I published in the *British Journal of Dermatology*, vol. xi, No. 125, illustrates most of the preceding characteristics of these "traumatic eczemas."

Mr. X—, aged 30 years, Demonstrator of Chemistry in a University College, was engaged in some research work, in addition to his ordinary duties in the laboratory. In July, 1894, he began to suffer from an irritable eruption on the fingers which kept appearing from time to time. After a while, this was accompanied by an acute vesicular eczema, affecting the face, ears, neck, elbows, inguinal regions, and scrotum. He was compelled to give up his work and undergo treatment, and after a time completely recovered. He returned to his work in the laboratory, and remained free for some time, when he had a recurrence of the generalised eczema, more severe than before. About this time he consulted a leading dermatologist in London, who confirmed the diagnosis of eczema. (I merely mention this point in order to emphasise my previous statement, that such cases are, clinically, indistinguishable from so-called "idiopathic eczema.") Suitable diet, more exercise, and less work were advised, and for a whole summer the patient was allowed only to do the minimum of demonstration work, and was out of doors golfing a large part of his time. With this *régime* his general health improved, and his skin recovered, to all appearances. After some months, thinking he must now be quite cured, he recommenced his research work in organic chemistry, only to be seized with a violent general recurrence worse than ever, and more widely spread.

Being a man of keen observation, he began to put two and two together. He bethought himself that these attacks, at first limited to his hands, had only occurred since he had been engaged in this particular research; that each recurrence had followed attempts to continue the research; that so long as he was only doing his ordinary laboratory work he remained free from any attack. Convinced that there was something in his research work which was the cause of these attacks, he proceeded to ascertain what it was by a process of exclusion, and, eventually, he proved conclusively that the offending irritant was one single substance—phenyl-hydrazin hydrochloride. A small quantity of this, touching his finger, produced within a few minutes great local irritation, followed by a vesicular eruption, and in a few hours by a severe, widely-spread acute eczema. After removing every trace of this substance from his laboratory, the attacks ceased completely, and although it is now six years ago, they have never recurred. There is not a trace of any eruption on his body at the present time.

I have given this case somewhat fully, because of its particularly clear and definite history. Similar cases, however, are of daily occurrence. Perhaps the most common instance is that of general eczema which so often follows a local varicose ulcer of the leg when it is irritated by an unsuitable application. At first the application makes the neighbouring skin on the leg inflamed and angry. Further applications are applied daily, and probably, but not necessarily, the other leg begins to be irritable; later the arms, neck, and face become itchy, and very soon a symmetrical eczematous eruption appears in those situations without any trace of eruption in the intervening skin. That these distal eruptions are of nervous origin, and possibly of a reflex nature, is probable from their symmetry, their appearance after the application of the irritant, their much milder type, and their frequent disappearance, without local treatment, very soon after the soothing of the originally irritated ulcer of the leg.

A similar condition is also common in cases of eczema of the hands,*

* J. F. Payne (*loc. cit.*, p. 511) writes: "The hands are often affected by various traumatic causes, such as those proceeding from certain occupations—washing, friction of tools, irritating substances, and so forth—that it is difficult to draw the line between traumatic dermatitis and eczema. But when an inflammation with the characters of eczema spreads beyond the part injured, continues when the irritation has ceased, and tends to become distributed in a

but it is here often difficult to prove, owing to the many irritants to which both the hands are daily or even hourly exposed.

That distal symmetrical eruptions can be produced by a localised irritant alone there is abundant evidence, but, that an irritant, applied to one side only of the body, can set up a dermatitis on a corresponding area of the opposite side, is not easy to prove.* It is difficult to show that the same external irritant has not also reached the opposite side directly. Thus, anything irritating one leg for several days, is often transferred to the other by the stockings being common to both; anything on one hand, is readily transferred to the other in the ordinary

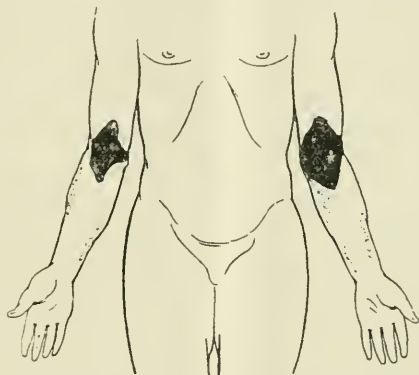


FIG. 5.—Symmetrical eruption on both arms following the application of irritating ointment to the left arm only.

movements of daily life; anything on the trunk, is easily conveyed to the opposite side by the movements of the body in bed, or by the hands; so also with the face or head.

The following case appears to be one in which most of these objections may be fairly eliminated.

A girl, aged 11 years (O. P., No. 3458), noticed some pimples on her arm seven days before coming to hospital, for which her mother typical manner, unrelated to the original seat of injury, and especially if it affect both hands when only one was subject to the trauma, it seems right to call the affection eczema."

* J. F. Payne (*Allbutt's System of Medicine*, vol. viii. p. 501, 1899), on this point writes as follows: "If, for instance, artificial dermatitis of one hand or arm is followed, not only by local extension, but also by appearance of the same lesion in the corresponding region on the other limb (as I can aver from personal experience) or in other parts untouched by the original irritant, no one could refuse to call the secondary eruption eczema whatever hypothesis might be framed to account for its appearance."

bought some green ointment. This was applied daily on a piece of rag, over the front of the *left elbow only*. Three days later the left elbow began to be sore and painful; the ointment was continued. The day before I saw her she noticed that the hollows of the *right elbow* began to be sore. She had never applied any ointment to it.

When I saw her first, the left elbow was covered with ointment spread on a rag and bound up with an old bandage; there was no dressing on the right arm.

Present condition (*vide* Fig. 5).—There is an acutely swollen, weeping area over the left elbow, on its flexor aspect, consisting of papules and vesicles on an inflamed base. The edge is fairly defined, and gives the patch a roughly diamond shape. Beyond this, and extending down the flexor surface of the forearm to the wrist, and a little way up the arm, there is a papular “lichenisation.” On the right arm, situated in a corresponding position over the hollow of the elbow, there is a diamond-shaped area of dry, finely scaling erythema, without vesicles, which in extent and shape is an almost exact replica of that on the left elbow. Extending from this down to the forearm there is very slight dry “lichenisation.”

One week later, after the application of boracic fomentations to the left elbow *only*, the patch on the right elbow had disappeared, and that on the left had become dry, with much exfoliation.

The green ointment which had been used was found to contain resin and wax, coloured with a green aniline dye.

My reasons for believing this to be an instance of what I referred to previously are as follows :

Direct transference of the irritating ointment by contact of the front of the right elbow with the front of the left is, as one can readily ascertain for oneself, a physical impossibility. Indirect transference of ointment from the left elbow to the right, by means of the hands, requires the intervention of both hands. Only the right hand can touch the left elbow, whilst only the left hand can touch the right elbow. No garments are worn in which the sleeves are used for either arm indiscriminately. The area on the right elbow corresponded almost exactly in shape and size with that on the left; it did not appear until the inflammation of the left elbow was at its height; it disappeared absolutely without treatment, when the opposite elbow was soothed and the irritant removed.

It may be said that in this case the dermatitis was not really caused by the ointment at all, that the spots on the left elbow, for which the ointment was bought, were "eczema," that the ointment merely irritated this and made it worse, and that the corresponding patch on the opposite elbow was simply another patch of eczema on a very common site, which, not having been irritated by the green ointment, was consequently less inflamed. Even if it be granted that the original left elbow lesion was eczema, that the injudicious application of the resin ointment irritated it unduly, the fact still remains that the corresponding patch on the right elbow did not arise until the area on the left elbow had been raised to a high state of inflammation, that it corresponded very closely in shape with it, and that it subsided and disappeared absolutely in a very few days, *without any local treatment* whatever, merely by the application of boracic fomentations to the opposite (left) elbow.

If the above case is accepted, it follows that in certain persons it is possible for an irritant, applied to one elbow only, to set up, not only a local irritation, but also to set going an eruption on the corresponding skin area of the opposite elbow. How far this statement can be extended to other parts of the body I am not prepared to say, but, so far as my observations go, I think that this power is more developed in the limbs and head than over the trunk. Possibly this may be associated with the relatively greater quantity of grey matter in the spinal segments of these parts, than in those segments connected with the trunk.

I have attempted during the preceding pages to make clear what I believe to be the characters of that form of eczema which for simplicity I have called traumatic, and I shall now endeavour to show that the period of infancy is one in which the opportunities of traumatism are, and must necessarily be, numerous. There are certain surrounding conditions present in infancy, which cease, as infancy emerges into childhood. These are necessary accompaniments of this period of life, and I shall endeavour to show that they are just as likely to produce irritation of the skin as those conditions of various kinds to which persons are exposed in adult life, in their various occupations or otherwise, and which we call "occupation or traumatic eczema." In other words, I believe that many, possibly most, cases of infantile eczema are, so to speak, the "occupation eczema of infancy," and that they usually

get well when the occupation (in this case it is that of being an infant) is given up—namely, in the course of the second or third year of life, sooner if efficiently treated, but, usually, whether treated or no.

What, then, are the particular duties in this “occupation of infancy”? During nine months previous to birth the infant has been surrounded, as to its surface, with a dilute saline solution at a constant temperature of about 100° F., the amniotic fluid. At birth, that constant warm liquid medium is suddenly changed for one which differs from it in three respects; viz. it is gaseous, instead of liquid, its temperature is considerably lowered, and its temperature is no longer constant. To these great changes the infant’s neuro-cutaneous apparatus has to accommodate itself. *As regards its skin*, therefore, the infant at birth changes from a subtropical aquatic existence, to a terrestrial life in a temperate zone.

Its skin, also, for the first time, makes acquaintance with various potential irritants—alkalis in the form of soap, micro-organisms which infest the hands and faces of all who handle it, sweat from its mother’s skin, the surface of its clothes, and of towels used for drying it. These are all new irritants to which the infant has to accustom itself. In other words, the infant is starting with some entirely new external conditions, which may or may not suit its skin, in which respect it is in a similar position to a person commencing a new occupation involving contact with material to which his skin has not previously been accustomed. Moreover, it must not be forgotten that an infant, during its first six months of life, has little or no power of localising or removing any of these irritants. Thus, if its clothes tickle and irritate, it has no power to remove the local irritant; it can merely cry; it is too young to scratch. When it is washed with bad soap which irritates its skin it cannot indicate the fact; when it is dried after washing, it cannot point out whether it is thoroughly dried or not. This last point is one of considerable importance. We all know that no one can dry our hands or face after washing as efficiently as we can do it ourselves; we also know that inefficient drying in cold weather is a fruitful source of sore hands and face. In an infant efficient drying depends entirely upon the nurse. The infant also has, as part of the “occupation of infancy,” to grow hair to cover his

scalp, to produce teeth, to accept food which is given to him, and to be vaccinated. Of these I have already referred in detail above.

It is a well-established fact that, as regards its nervous system, the infant is more allied to a lower type of creature than is the adult. Its highly developed and uncontrolled lower reflexes show this clearly, as, for example, the bladder, the rectal, or the stomach reflex. In the same way its neuro-cutaneous reflexes are present to an extent which is largely lost in adult life. Thus, whilst in an adult the so-called superficial skin reflexes are limited to a few particular areas where they still persist, viz. the soles of the feet, the groins, the flanks, etc., in the infant, the skin of the whole body is an almost continuous sheet of reflexes. If the back of an infant is stroked or prodded with the finger, there is a reflex flinching at every point touched. Sometimes this persists even into adult life, but this is an exception to the rule. In familiar language, we say that a child is "ticklish." * This reflex irritability of the infant's skin shows a hypersensitiveness to external irritants, which, coupled with the impossibility of removing them, plays an important part in the starting of eczema.

As the infant develops, its power of removing irritants from any spot becomes greater, and, if it is already affected with an irritable condition, such as eczema, this power is made use of to the detriment of the patient, so that what originally was intended to prevent and protect, becomes, under these circumstances, a source of further irritation. This makes infantile eczema, once it is thoroughly established, so difficult to treat successfully.

Any one or more of these external conditions which make up this "occupation of infancy" may be accredited with starting eczema. There are at least six which are more or less constantly present. They are: (a) chill to the skin (sudden changes of temperature); (b) imperfect drying; (c) soaps; (d) irritating dust in atmosphere; (e) micro-organisms; (f) sweat of mother's skin.

The most striking reason for suspecting that such external irritants are, some or all of them, the cause is the fact that in 95 per cent. of these cases the rash first showed itself in practically the only exposed part of the whole infant, namely the head or face, the rest of its

* It is worth noting in this connection that many of the "ticklish" parts of the body surface in adult life are common sites of eczema—the elbow hollows, the axillæ, the neck and ears, the insides of the thighs, and about the scrotum.

surface during the first month being swathed and protected at every point. And I may here remark that the scalp of the average infant is so scantily provided with hair that for all practical purposes it is hardly more protected than the face.

Of these six classes of irritants, there is, in most cases, a likelihood of some or all of them acting together, and to attempt to say which of them, alone, is the chief cause of the eczema, is often impossible. But in certain cases one or more may predominate and play a larger share than the rest. As we have seen, there is evidence that the bulk of the cases begin in the colder periods of the year, and therefore I should be disposed to give the greatest importance to cold as the predominating irritant. This will undoubtedly also influence any imperfect drying of the skin after washing. We are all familiar with the readiness with which persons get chapped hands in winter if they have to wash frequently, and especially if they fail to dry their hands carefully, and there is no reason to see why the infant should not get repeated and very effectual irritation from what may be termed chapped face. If to that be added an irritating soap, such as is so frequently used by the poor, and even by the well-to-do, we have a combination of very powerful irritants. And one can readily see why this is more likely to affect the face than the rest of the body in a young infant; because, after the general bath, in which the same soap, the same water, and the same inefficient drying, may be used, the body and limbs are at once covered with clothes, so that moisture is absorbed and the clothes prevent evaporation or the contact of cold air with the newly-washed surface. In the case of the face and head this is not so. Then, again, the child's face is the only part which is freely exposed when the child is taken out, or, in the cottages of the poor, with the room door opening on to the street, when it is near the door in that room.

How far irritating particles, such as smuts, etc., in the atmosphere, help with the other irritants, it is difficult to say; but, inasmuch as they tend to soil the face, and consequently increase the vigour and frequency of washing, I can readily believe that they may do so indirectly. That micro-organisms may, and do, play an important part in infantile eczema, I fully believe, but that they act in any other way than secondarily, I am not convinced. These micro-organisms may be classified under two heads, representing the only

varieties with whose frequent action we are at all familiar in these cases. Of these two, there is, first, the group which causes *Impetigo contagiosa*. These, it is generally agreed, are always a secondary infection following the eczematous lesion, and often almost masking it. We may, therefore, dismiss them for the present. The other group is that which is believed to cause the lesions which we know as *seborrhoeic dermatitis*, which I believe is a clinical entity, but which I cannot accept as being equivalent with eczema. Now, whilst I am quite prepared to admit that some of these cases of infantile eczema may, and do, begin as a *seborrhoeic dermatitis*, by direct infection from the skin of a *seborrhoeic* mother or nurse, yet I am quite unable to accept the statement, that they are such from beginning to end, and, that every portion of eruption, even those on distant parts of the body, every vesicle, every papule, every patch of erythema, is due to a local infection by these organisms. If this were so, it would be impossible to find the symmetry which one does find, or to see why the lesions should not spread peripherally to a greater extent than they do. But I feel that, besides these cases in which, possibly, a direct *seborrhoeic* infection from the mother's skin may be the primary source of irritation, there are many more in which the *seborrhœa* becomes, as does the *impetigo*, grafted on the already irritated and eczematous skin, so that, whilst helping to keep up the irritation and to complicate the picture, it has been in no sense causative of the original condition.

Lastly, the irritation which may be caused by the mother's sweat is merely referred to, because the child is repeatedly in contact with the mother's warm breast, when suckling, and the seat of commencement of eruption is so frequently the cheek, which would during those times be exposed to such irritation. But, as I said before, I have no conclusive evidence to support any definite statement on the subject.

I have thus endeavoured to show that (1) An infant is exposed to many new external surroundings, which are capable of acting as irritants; (2) that the most exposed part of its surface is in almost all cases the starting-point of the eruption; (3) that the skin reflexes are far more widely distributed, and easily called forth, in an infant than in an adult; (4) that whilst, in most of the points upon which inquiry has been made in these sixty cases, the evidence has been

uncertain or distinctly opposed to their being causal, there is evidence that most of the cases began in the colder seasons of the year.

In conclusion, I venture to suggest that what is generally called eczema, whether it occur in infants or adults, is a form of reaction or response of the neuro-cutaneous apparatus to external irritation; that it does not exist in most people; that in many it is only called forth under exceptional forms of irritant, or at times of exceptional nervous irritability; that in a few it is so readily aroused, even by the ordinary external stimuli of daily life, that they are constantly affected.

One can hardly suppose that such an elaborate neuro-cutaneous response is purposeless, any more than that inflammation is purposeless. It seems more rational to suppose, that such a reaction is intended to serve some purpose, possibly to remove the irritant or to protect the skin surface. May it not be the rudimentary remains of some once-important function of the skin? A function which, under the present conditions of life, has ceased to be effective, and which, like other rudimentary organs and functions, is more often detrimental than useful.

SOCIETY INTELLIGENCE.

THE DERMATOLOGICAL SOCIETY OF LONDON.

A MEETING of this Society was held on Wednesday, July 12th, 1905, Dr. J. J. Pringle in the chair.

The following cases and specimens were shown:

Mr. WILLMOTT EVANS showed (1) a case of localised *sclerodermia* (*morphea*). The patient was a woman, aged 51 years, and for ten months she had noticed a hardening of the skin of the loins; this hardening had later spread to the abdomen. When first seen she had a few pustules and crusts on the loins, caused by scratching, but these soon healed with a mild mercurial ointment. Over the whole of the lumbar region the skin was hard and of an old-ivory colour; on the sides of the abdomen and anteriorly were numerous whitish patches of hardened skin, surrounded by a lilac-tinted zone with telangiectases. There was a tendency to symmetry; and the longi-

tudinal axis of most of the isolated patches was directed horizontally, thus according with the distribution of the arteries rather than with the nerves, which have a well-marked oblique direction. Sensation was but little affected on the sclerosed patches, but the patient complained much of itching. There was nothing in the history to throw light on the causation of the disease.

(2) A case of *xanthoma*. The patient was a woman, aged 34 years, and for the last eighteen months she had noticed the appearance of yellowish nodules in the skin. They appeared first on the elbows and then in the palms of the hands. When seen she had numerous yellow nodules over the elbows, and yellow lines occupied all the flexure-grooves of the palms and fingers. On the dorsa also of the hands the same yellow nodules were seen, especially on the knuckles. At the flexure of the wrists and on the grooves of the neck the same yellow lines were visible, but were fainter. A few nodules occurred on the knees. Some irritation was present. There was no jaundice, and none had been present at any time. There was no sugar in the urine.

Dr. GALLOWAY showed (1) a case of *persistent exudative erythema*. The patient, a young woman, aged about 30 years, had previously been brought before the Society by Mr. Dore. The history of her case is that on coming to London from the country for employment in domestic service nine years ago she began to suffer from her present illness. There appeared symmetrically distributed, on both cheeks and centre of the face, an erythematous raised eruption with distinct circinate outlines. The eruption, commencing as a small patch of redness, spread peripherally, until large areas of the face were affected, when the condition seemed to have attained a resting state. The eruption then consisted of symmetrically disposed erythematous areas with circinate margins, the central portions being paler than the margins, which were distinctly raised above the surface of the skin and firmly œdematous.

After some months the eruption would gradually disappear till, according to the patient's account, it vanished entirely, no scar nor visible atrophy of the skin remaining. The disease occurred in the first instance during the early part of winter, lasting during the cold weather, and disappeared in summer, but during the present year the

eruption had occurred again in May and was now in full development. No patches of disease were observed in any other part of the body, though it was stated that before the occurrence of the present eruption she had frequently suffered from chilblains, which now no longer appeared. No disease of the heart, blood-vessels, or lungs could be determined, and the patient appeared to be in good health.

Dr. Galloway hoped to admit the patient to hospital later so as to be able to investigate more closely the relations of the disease. At present he drew attention to the condition as showing the close resemblance between certain forms of Erythema multiforme and the condition recognised as Lupus erythematosus. He remarked that evidence appeared to be accumulating which pointed to a connection between what would be recognised clinically as Lupus erythematosus and certain disorders of internal viscera, especially the kidneys, and possibly also the gastro-intestinal tract and liver. On the other hand, the relations between disorders of the alimentary tract and of metabolism with eruptions of Erythema multiforme were recognised to be frequently of a very close character. A case such as the one before the Society might be regarded as being on the border-land between Lupus erythematosus and Erythema multiforme, and in all probability the exciting cause of the disease might be found in some internal disorder not yet discovered.

Mr. DORE corroborated the account of the case as given by Dr. Galloway, and described the course of treatment which he had previously used in her case. He had made use of many internal remedies, but mainly salicin and salol. Locally he had used sedative applications, and had also made use of applications of high-frequency electric currents.

Dr. WILFRID WARDE drew attention to the fact that some cases commencing clearly as Erythema multiforme of the face had, in his experience, gradually after several attacks assumed the characteristics of Lupus erythematosus, and he considered that it was important to note in the case of this patient that the disease had now occurred, not only as at first in the winter, but also in the summer. The persistent lesions thus produced might readily produce the atrophic changes which, by their absence, distinguished the disease from Lupus erythematosus.

(2) A man, aged 38 years, who presented a well-characterised eruption of *Lichen planus* of the nodular type on the forearms, especially on the flexor aspects of the wrists. The diagnosis having been agreed to by members of the Society, Dr. Galloway then showed that the man

suffered from a typical eruption of Alopecia areata of the scalp, and across one of the larger patches at the back of the head could be readily seen a considerable area of Lichen planus of the atrophic type. Dr. Galloway remarked on the curious coincidence of the two diseases.

Dr. GRAHAM LITTLE showed (1) a case of *Keratosis follicularis* (Lichen spinulosus) in a girl, aged 11 years. She was one of six children, none of the others being affected. The condition had been present about five months; there was considerable itching but with this exception there were no subjective symptoms, and the eruption was left alone, the patient being brought to hospital because she had concurrent ringworm. Characteristic follicular papules and spines were arranged in groups with the following distribution: On the back of both elbows there was a large patch of grouped papules, with scattered papules upon the upper arm to the level of the shoulder; there were grouped papules on the fronts and backs of both knees and scattered papules along the anterior surfaces of both legs; there was a small group of closely set papules in the fold of the skin below the buttock on both sides, forming a patch the size of a florin. The nucha was covered with small spiny papules, but the back and front of the trunk were free, with the exception of a small group on the side of the chest below the axillæ. The spines of these lesions were quite a sixteenth of an inch long; the intervening skin between the papules was normal as far as could be seen with the naked eye.

The nomenclature of this group of diseases was very indeterminate. An admirable contribution to reducing order out of chaos has been made in a recent paper on the subject of Lichen spinulosus by Dr. Adamson in the *British Journal of Dermatology*; but it seemed, at any rate to the exhibitor, unfortunate to perpetuate the term of *Lichen spinulosus* if by this term any association with Lichen planus was intended to be assumed. The case now shown was indistinguishable, clinically, from the cases of *Keratosis follicularis contagiosa* (Brooke's disease) shown by Dr. Little at this Society in October, 1901, and accepted by Brooke, who subsequently saw them, as being of the same type as the earlier cases described by him. The single fact of apparent communicability in these cases did not suffice to separate them, and it might well happen that contagion might take place later, since

in Dr. Little's "contagious" cases above mentioned one child had had the disease for two years before the second child became affected.

(2) A case of *abnormal variation of pigmentation of the hair* in a boy, aged 9 years, the brother of the patient described above; the boy's hair was of a sandy colour, except for a small patch the size of a sixpence upon the vertex, which was of a jet black. There was no disorder of pigmentation of the skin either in this black patch or elsewhere. The black patch had been noted all his life in this position.

(3) A case of *Urticaria pigmentosa* in a little Jewish boy, aged 3 years, a recent patient of Mr. C. S. Ballance, to whom Dr. Little was indebted for permission to show the case. The child had been in Great Ormond Street Hospital for multiple abscesses and bone disease, and was in delicate health from this cause. He had very extensive macular *Urticaria pigmentosa*, the trunk being chiefly affected. He had had the disease since the age of 2 months, and the mother was positive that he had not any rash on the body at his birth. There were three other children, who remained entirely free from the disease. There was nothing in the history of the mother during pregnancy to throw light on the development or the origin of the affection in the child. A section had been obtained, by the kindness of Mr. Ballance, and the characteristic appearances of *Urticaria pigmentosa* were demonstrable.

(4) A second case of *Urticaria pigmentosa* in a little girl, aged about 8 years, which was remarkable for the small extent of the eruption, there being, in fact, only *two* lesions of the disease. One of these had been excised and sections from this showed the usual facts typical of this disease. Both lesions were present on the back within three inches of each other, the colour being a light brown, the patches quite flat, and of the size of a sixpenny-piece. They had been diagnosed as "birth-marks," and had persisted unchanged since birth up to the time of the biopsy. No fresh spots had come out. The lesions became turgid and red upon scratching, in the usual manner observed in this disease. In view of the extraordinarily restricted area of the eruption scepticism might well be expressed at the diagnosis, but the microscopical appearances were absolutely conclusive in confirming the diagnosis offered.

Mr. MALCOLM MORRIS showed three cases, in one family, for diagnosis and submitted the following memorandum :

Edward E—, aged 19 years, was healthy as a baby ; a small wart was noticed on his chin at 2 years. This was burnt off by a doctor, but was followed by similar warts on left side of chin and nose. As years went by they came all over the face. He never had any freckles when he was little. The warts used to increase in size, but now come and die away again. There were also some warts on his wrists and hands and neck. There was an increased growth of hair at about 12 years.

Kate E—, aged 11 years. A small wart was noticed on the lip at 3 years. Nothing further was noticed for a year, then several warts appeared. There was an increase of hair-growth since December last year.

Eileen E—, aged 11 years, twin sister of Kate. There was a small wart on the nose at 3 or 4 years, followed by others all over the face. An increase of hair was noticed in November.

There was no previous illness in any of them. The faces of all three were freckled, generally pigmented, and covered with small warts. The lesions began as a thickening of the skin, which was brown in colour. There was then a hollowing of the centre, and a brown ring formed, which spread centrifugally ; left a scar ; was worse in summer, and better when protected from the sun. The lesions itched and burned, especially after rain and when sun was specially strong.

Family history.—They lived at King Williamstown, South Africa, forty-two miles from coast, and 1500 feet in altitude. The father and mother were healthy ; two other children were perfectly healthy, a girl of 17 years and a boy of 15 years between Edward and the two girls.

Mr. MALCOLM MORRIS did not come to any diagnosis, and Dr. H. RADCLIFFE-CROCKER, who had also seen these cases in private, considered that they fell into no known category of disease, and were *sui generis*. It was suggested by some members present that these were anomalous cases of Xeroderma pigmentosa, but no diagnosis was generally accepted.

Mr. GEORGE PERNET showed a specimen of *moniliform deformity of the pubic hairs*. The patient was a man, aged 44 years, who was attending University College Hospital for syphilis. The hairs of the pubes were very sparse, short, and crinkly, giving a singed appear-

ance to the parts. According to the patient this had existed for years. It was not due to the syphilis, although when he first came under observation he had the scars of two recent sores, no doubt primary, on the pubes. The hairs showed irregular longish fusiform swellings, the root ends exhibiting atrophy, and the free ends being more or less brush-like. The pigment was either absent or much fragmented.

Dr. J. J. PRINGLE brought forward (1) a case of *Dermatitis herpetiformis* in a man, aged about 30 years, who had suffered from syphilis some years ago, had been extremely intemperate in his abuse of alcohol, and was liable to attacks of an hysterio-epileptic character. He came under the exhibitor's observation in 1902, under whose care he remained in the Middlesex Hospital during the months of August and September. The eruption had first appeared early in that year on the face and about the wrists, but when first seen it was also present in abundance on the neck, axillæ, groins, thighs, buttocks, legs, and, to a less extent, on the chest and scalp. The lesions were typical, herpetically grouped vesicles on erythematous bases, accompanied by severe itching and soon becoming pustular and scabbed. A few blebs were present on the buccal and palatal mucous membrane, and there was marked conjunctivitis. After two months' treatment with prolonged boric baths, rest in bed in the intervals, three-minim doses of Fowler's solution three times daily, and adrenalin to the conjunctivæ, the condition entirely subsided, and he left the hospital, being subsequently lost sight of. He re-appeared at the Out-Patient Department on July 6th of the present year and presented a very sad spectacle. The distribution of the lesions was the same as above noted, but there was much superadded pus infection from lack of proper attention. Both corneæ were opaque, and the patient consequently quite blind, but there was no material so-called "shrinking" of the conjunctivæ. The patient and his relatives stated that he had been continuously affected with this disorder since the beginning of 1903, and that every attempt to institute treatment by arsenic had been followed by an acute exacerbation of all its manifestations.

(2) A man, aged 32 years, a sandpaperer, suffering from typical *Lupus erythematosus* of maximum intensity on the vermillion of the lower

lip. The condition, which was of quite typical character, began four years ago, affecting the nose, malar regions, and ears. Three years ago the lower lip was first attacked, and when exhibited it was much swollen, everted, superficially ulcerated, and intensely sore. The whole of the buccal mucous membrane was distinctly involved, being thickened and opalescent, but nowhere eroded; during the previous six weeks remarkable improvement had occurred both in its condition and that of the face. This tended to confirm the patient's statement that the lip had frequently recovered spontaneously during the three years of its involvmenting. He also suffered from extensive alopecia areata of five years' duration, during which the hair of the scalp had fallen off completely three or four times. There was nothing suggestive of syphilis about the case, and the association of Lupus erythematosus with alopecia areata was regarded as purely fortuitous, both by the exhibitor and the other members of the Society present.

Mr. SICHEL showed the following cases :

(1) A case of *Epidermolysis bullosa*, under the care of Sir Cooper Perry. The patient is a man aged 31 years, a painter by trade. The disease began when he was 2 years old; he knows of no cause for it, but there is the history of a fall into dirty water when an infant, after which he had the "blister-pock." Family history negative; he has ten brothers and sisters, all healthy. Whenever he knocks himself he gets a bulla, which is sometimes hæmorrhagic. Sometimes the bulla dies away without leaving a sore place, at others a superficial ulcer remains, which results in a scar. In this way he has lost all his nails, and the hands, feet, elbows, knees, face, and scalp are cicatricial. He also gets blisters on the mucous membrane of the mouth, and his tongue is so bound down that it cannot be protruded. Over both buttocks the superficial layers of the epidermis are loose and wrinkled into a network of ridges, the appearance somewhat resembling the rind of a net-melon. The cicatricial alopecia has developed in the last six months. There are scattered freckles on the face, and slightly on the backs of the hands. The skin generally is atrophic, being thin and shiny. Dr. French, the Medical Registrar at Guy's, made a differential blood-count: Polymorphonuclear 56.4 per cent., small lymphocytes 38.0 per cent., large lymphocytes 4.0 per cent., eosinophiles 1.2 per cent., basophiles 0.4 per cent.

(2) A case of *congenital tumours of the fingers* of the left hand, under the care Mr. F. J. Steward. The patient is a little girl, aged 6 years. She has multiple, hard, painless tumours of the skin of the inner three digits of the left hand, which have been there since birth. The largest covers an area about the size of the adult thumb-nail. Hæmorrhagic effusion appears to have taken place into most of the larger tumours, and caused bruise-like discoloration. Many of the tumours have been removed by the knife, and keloid-like scars are left as evidence of previous operations. Epitrochlear and axillary glands not enlarged. Patient has a slight degree of xerodermia. The tumours microscopically were found to be fibromatous.

Dr. WHITFIELD recognised the case as being of the same nature as a series of cases first reported in the *Medico-Chirurgical Transactions*, by Dr. Murray in 1873, and again in 1903 by Drs. Whitfield and Robinson ("Remarkable Series of Cases of Molluscum Fibrosum in Children").

(3) A case of *Nævus pigmentosus* under the care of Sir Cooper Perry, in a small, rickety, very undersized girl, aged $2\frac{1}{2}$ years, admitted into Guy's Hospital for cough and wasting. The pigmented patch covers the front of the left knee, and consists of a darker centre and lighter periphery, each very well defined. The patch as a whole is not raised above the surrounding skin, but scattered over the darker central area are numerous, smooth, rounded, soft nodules, varying in size from a pin's head to half a pea. The affected area has not increased in size while the child has been under observation (about three weeks). It is said to have begun ten months ago in a patch about the size of a threepenny-bit, but this history is doubtful.

(4) A case of *rodent ulcer* in a man, aged 52 years, which had disappeared under the influence of X-rays.

Dr. WHITFIELD showed a middle-aged woman suffering from an *acuminate spiny eruption* on the body and limbs. The history was that the eruption had come out suddenly about Easter, 1905, affecting first the trunk, and had then very slowly spread on to the limbs and become denser on the body. Itching was intolerable, but otherwise there were no symptoms of disturbance on the part of the patient.

On examination the whole of the trunk was found to be covered with a scattered eruption of minute follicular papules of about the same size as those of the common follicular syphilide, to which indeed

the eruption bore a strong resemblance. The parts most affected were the neck, the intermammary region, and the skin over the scapulæ. In these parts each papule was of particularly firm consistence and carried a dark spine. On the arms the rash affected the flexures of the elbows chiefly and there the papules were pinker and carried no spines. On the legs there were curious little groups of papules, some carrying spines but others being almost plane.

There was a very marked band of them round the lower part of the trunk and some on the buttocks. There were no lesions of mucous membranes.

In addition to this the patient was almost bald from a cicatrising alopecia of the type of which many cases have been shown to the Dermatological Society of London, in which the hair may be pulled out without effort, bringing with it the root-sheaths. This condition had been gradually progressive and had lasted for very many years, having begun when the patient was a young girl. Dr. Whitfield said he considered that the two lesions were unconnected and he offered the diagnosis of acuminate Lichen planus for the widespread eruption, though he expected to elicit different opinions from different members.

Some of the members thought that the head and body lesions were connected as part of the same process, having seen the co-existence of these in other cases.

Dr. RADCLIFFE-CROCKER believed the case to be unconnected with Lichen spinulosus.

Dr. PRINGLE was inclined to agree with the exhibitor's diagnosis.

Dr. COLCOTT FOX was of opinion that it was most likely a form of seborrhoeic folliculitis, and suggested the use of sulphur externally.

Dr. WHITFIELD said that he would certainly order sulphur to be used and report on the case again. He thought, however, that the really spiny cases of seborrhoeic folliculitis were limited to children, and that the lesions in this case, apart from the spines, were too hard, and not sufficiently spongy for a "séborrhéide."

CURRENT LITERATURE.

MERCURIAL INJECTIONS. (*Cong. Françaises de Med.*, Paris, October, 1904; *La Syphilis*, January, 1905.)

M. LANNOIS (of Lyons), after giving a short history of the method of treatment by mercurial injections, said the time had now arrived—(1) for a careful examination of the different formule and their mode of action; (2) for a comparative

study of the advantages and inconveniences with other modes of treatment; (3) for a careful examination of the clinical results obtained. He alluded to Professor Bouchard's method of local injections in minimum doses, used by oculists—subconjunctival, and by neuropathologists—sub-arachnoidal, and then proceeded to discuss the question as part of general treatment—(a) the method of daily injections of the soluble salts, giving the same, or a progressively increasing dose, such as will meet the daily needs of the syphilitic organism; (b) the method of less frequent injections (insoluble as a rule); thus providing the organism with a store of mercury, on which it may call according to its needs.

These two methods have their advantages and their drawbacks; each has its own peculiar indications. They are not to be considered as in opposition, but rather as complementary the one to the other. They should be carried out with the strictest asepsis and very deeply into the upper and outer part of the buttock.

Subcutaneous injections give rise to local and painful lesions. Intra-venous injections, a more delicate operation, do not give superior results. It would be interesting, he said, to trace in detail the series of processes, chemical and biological, local and general, produced under the following heads:

(1) A local action, produced by the peculiar and irritative action every mercurial injection possesses with regard to the tissues, and which shows itself by painful and inflammatory phenomena, the duration and gravity of which vary with the preparation used. This local action supervenes during the absorption and perhaps chemical change of the salt, before its passage into the general circulation.

(2) A general specific action; this will depend on the valency of mercury in the salt used, but not entirely, for, according to Merget and Pouchet, mercury circulates in the blood in the metallic state, so that one must take into account the state of combination of the mercury; the facility with which it is set at liberty, circulates, and is retained in the blood.

(3) A toxic action, rarely due to the effects of metallic mercury, but more frequently to the formation of an excess of hyd. perchl., to which is often added the presence of a harmful radical entering into the composition of the mercurial molecule injected (cyanide), and sometimes the influence of a local anæsthetic (eocaine).

The ideal injection should give: (1) a maximum specific action; (2) a minimum local action; (3) a minimum toxic action. In practice, the injection should give rise to a minimum irritative action on the tissues. It should be painless, or nearly so. It should be rich in mercury. It should easily break up and be readily absorbable. It should be non-toxic. It should have no toxic radical. It should not be affected by the addition of an anæsthetic. Its formula should be as simple as possible. Local absorption is often very rapid, and may be followed by examining the urine or by radioscopy if insoluble salts be used. Leucocytes play a large share in the local absorption of mercury. The iodides and sulphides favour the elimination of mercury.

Of the preparations used, M. Lannois prefers: (1) the biniodide in aqueous solution, which seldom gives rise to troubles and may be used in large doses. The biniodide in oily solutions requires more delicacy in handling and is more painful; (2) the benzoate of mercury. The hermophenyl, lactate, and neuter salicylate salts are also used. The cyanide and oxycyanide are dangerous,

Of the insoluble preparations he preferred calomel and gray oil.

In treatment by injections we have the most powerful method of combating syphilis. In every case where a grave lesion calls for the "traitement d'assaut de Charcot," such as a gross nervous lesion (coma or paralytic stroke), threatening to terminate the days of the patient, where an important organ is threatened (larynx, the eye or ear), in cases of severe phagedænic ulceration, cases resisting other lines of treatment, cases where rapid diagnosis is required, this method should be the treatment used. At the same time, it should be remembered that ordinary cases do not require such extensive treatment, which should be kept for special cases only.

The medical manifestations of syphilis are numerous. Some may be called precocious, others later and chronic, classified as parasyphilides—a most useful term, as it allows of the separating into two distinct groups of symptoms, which are very different in the evolutionary characters and very different in their reaction to remedies. One must remember that in these purely medical manifestations it is only certain of them which will yield to mercury. The older the syphilis the nearer one is approaching a condition of sclerosis, and one cannot agree with Leredde that tabes and general paralysis should be curable because they are syphilitic.

M. BALZER (of Paris) said the treatment of syphilis consists of the impregnation of the organism with mercury (mercurisation) in a fixed time (*curis mercurielles*). Mercury exercises a truly specific action against the pathogenic agent, not only destroying, but preventing its development, in addition to which it probably has an indirect specific action in causing the production of alexines, thanks to which the pathogenic agent is neutralised, weakened, and even destroyed.

The organism itself probably furnishes an antitoxin, for some cases are spontaneously cured without the intervention of specific remedies.

Syphilographers may be divided into three classes: (1) Those who consider that the organism can throw off the disease and that mercury is positively harmful; (2) the opportunists who only give mercury during the presence of symptoms; (3) those who continue the mercury also during the latent stages.

According to some authorities mercury is absorbed and circulates as chlor-albuminates or oxychloralbuminates; others, that it exists in the blood as the metal in very fine division. In the urine it is found only as metallic mercury. The leucocytes play an important part—they not only absorb the microbes and antitoxins, but act as carriers to the diseased parts of mercury and iodides. One should be careful not to overtax them, and the too rapid diminution of the leucocytes is a sign one should not neglect.

Whatever the theories, mercury acts by impregnating the cellular elements, and if it circulates in the state of solution in which it is injected into the tissues, its action will be a minimum, because it will be so quickly eliminated; its maximum action will be obtained when it is in such a form that it tends to combine with the elements found in the blood and tissues. Therefore, as Merget says, no injectable preparation can be so efficacious as mercury itself, and the gray oil is the preparation.

Its action on the blood.—It increases the hamatin and quantity of hamoglobin lowered by syphilis; the leucocytes, and especially the lymphocytes, increased by syphilis, are diminished. The limitation of utilisation of mercury by the organism

is fixed by the capacity for absorption and elimination of the elements found in the blood and tissues.

With calomel injections mercury appears in the urine in a few hours, reaching its maximum the third or fifth day. With inunction and ingestion its appearance in the urine is much slower, reaching the maximum the fifteenth to the twenty-fifth day. Therefore, from the view of rapidity of action, the superiority of treatment by injections is undeniable.

The integrity of function of the different viscera—liver, kidneys, etc., is an indispensable condition for the proper carrying out of the treatment, especially in pregnant women. Syphilitic and albuminuric: (1) The absorption of injected mercury is rapid, as shown by its prompt appearance in the urine: (2) the daily elimination is limited; (3) part of the mercury absorbed accumulates in the organism which under normal conditions can support a considerable amount.

If fresh injections pass this tolerance point intoxication will be imminent, owing to the insufficiency of the channels of elimination.

The local disadvantage of the soluble salts are (1) pain often increased by the daily injections, (2) inflammatory nodules, (3) abscess, (4) gangrene. The general disadvantages show themselves chiefly in the channels of elimination, gingivitis, nephritis, erythrodermia, diarrhoea, nutrition troubles, loss of weight, anæmia, diminution of hæmoglobin, leucocytes, etc. The advantages are exactness of dosage, the rapidity and energy of the therapeutic action, the absence of serious accident if average doses only be employed.

An average dose for a young adult is 1 centigramme of mercury a day, whatever the preparation used; thus with salts rich in mercury (the sublimate or cyanide) 1 cg. per diem; with salts less rich (the biniodide or benzoate) 1½ to 2 cgs. The course is twenty or thirty days, according to the case, and one should always start with an average dose. The stronger course consists of the daily injection of 2 cgs. of sublimate or cyanide, 3 or 4 cgs. of the biniodide or benzoate, for three weeks. The daily dose of mercury injected should seldom exceed 2 cgs. and only the soluble preparations used. The intensive cure, soluble preparations only, consists of a maximum dosage of 3 cgs. of mercury per diem, and should be used only in very special cases.

Lukaziewicz and Cheron give 30 to 40 cgs. of mercury in doses of 5 cgs. in four to six weeks. This is not dangerous, but it is preferable to use the insoluble preparations. This intensive method is based on the principle that mercury injected is so rapidly passed into the circulation, and is so rapidly eliminated that intoxication is not to be feared.

The mercurial solution is decomposed thus: (1) One part is immediately absorbed, the transformation taking place finally in the blood or tissues; (2) one part remains at the seat of injection, combined with the serum, as an albuminate to be absorbed later and progressively; (3) one part is fixed in the organism in certain viscera, large intestine, liver, kidneys, glands, etc.; (4) a portion is eliminated daily in the urine; this quantity varies but little, whatever the dose injected or the preparation used.

The accumulation of the mercury fixed in the organism ought then to be increased gradually and proportionally to the doses injected, and it would be logical to inject daily only that quantity of mercury which the blood could take up, and which could be eliminated in twenty-four hours; this is called the physiological

dose. Intra-venous injections are also rapid in action, for from the beginning they reach the goal (the blood) of all mercurial treatment. The dosage is small, generally less than 1 cg. of cyanide or the sublimate, and raised only with difficulty to 1½ cg. Intolerance may show itself promptly by diarrhœa in five or six hours, showing that the salt injected had traversed the circulation so quickly that it has not had time to become fixed in the different organs. The method is indicated in the infective stages, in secondary cephalitis, in syphilis of the vascular system, in cerebral and ocular syphilis, but neither in intensity nor in continuity of action can it compare with other methods.

Of the insoluble preparations one prefers calomel and gray oil. Thirty or 40 cgs. of mercury are injected in 7 cg. doses per week for four or five weeks. The stronger cure consists of 10 cgs. of calomel, yellow oxide, or mercury weekly for two or three weeks—then fortnightly; total dosage 50 to 60 cgs. mercury.

The mode of action rests on the following principle: The injection of such a large quantity of mercury will be slowly transformed and absorbed, and an energetic and prolonged action without any great risk of intoxication maintained. The risks incurred with these large doses of insoluble preparations are, firstly, local accidents; pain, lesions of nerves, aseptic and phlegmonous abscesses and pulmonary embolisms; secondly, the general accidents; these are the same as with the soluble preparations.

The patient should be carefully weighed during the treatment, and any diminution noticed must be accepted as an indication to cease or modify the treatment.

In the discussion that followed:

M. JULLEN said he had used with great success the preparation levurargyre. Speaking of the insoluble preparations, he said he could only repeat a remark he made thirty-five years ago that calomel is a marvellous drug; it is well borne, and especially if used according to the formulæ of Scarenzio. It is particularly useful in the treatment of chancre (abortion) and in all lesions threatening important and delicate organs. Gray oil he thinks less heroic but suitable for ordinary cases, though a careful watch must be kept on the organs of elimination. It should not be used in cases of albuminuria and is of but little service in severe nerve lesions.

M. HALLOPEAU thinks that in many cases one gets quite as good results with innunction. And when he does use injections he uses the soluble salts in preference to gray oil, the action of which is more slow by reason of the work required for the resorption by the lymphocytes of the molecules of mercury introduced into the tissues.

M. ABADIE thought that intra-venous injections formed the best treatment for syphilis, especially in cases of chorioretinitis and certain forms of optic nerve atrophy, and also wished to call attention to this form of treatment in cases non-syphilitic, sympathetic ophthalmia and certain cerebro-spinal affections.

M. LEREDDE would not allow that the injection of mercury in large doses was attended by any very special results, and thought that the answer to the question of curability of parasyphilides might possibly be solved (a) by a method of comparison, *e.g.* by dividing twenty tabetics or twenty general paralytics into two series and treating one set by the intensive method, (b) or by the employment of the intensive treatment in patients with commencing tabetic amblyopia. Three

opinions on the subject were to be sought: (1) The patients were healed; (2) the patients were not healed; (3) the treatment was dangerous. If it could be shown that the patients were cured then it would be proved that one manifestation undoubtedly tabetic is curable. The solution of the question would be further advanced if it were shown that the cephalo-rachidian lymphocytosis of commencing tabes or general paralysis were cured by the intensive treatment. One case he had in the space of a year showed marked diminution in the lymphocytosis, the patient, in his opinion, being one of commencing general paralysis.

Professor FOURNIER said that in treating parasyphilitic troubles with as much as 10 cgs. of calomel or gray oil he had had no good results, and he thought his experience was the same as that of the neuropathologists. He had no hesitation in applying the word "miraculeuse" to calomel, and quoted a case of a horrible tubercular syphilide of the face which had yielded to a single injection of calomel. He thought it should be reserved for special cases, and would use it for the following six conditions: (1) *Phagedenic chancre*. He recalled a case of phagedenic chancre which had destroyed a portion of the tongue which yielded in a few days to a single injection of calomel; (2) *tertiary phagedena* in nose cases, or where there were terrible mutilations; (3) *tubercular syphilides, dry or crustaceous*; (4) *gunmatous laryngitis*; (5) *chronic palmur or plantar psoriasis*; (6) there is an organ, one might call *the organ of calomel*, viz. the tongue, since all lesions here, sclerosing glossitis, chronic secondary glossitis, etc., yield rapidly to calomel injections. There are cases where calomel seems to exert but little influence, *e. g.* iritis and iridochoroiditis. In cerebro-medullary syphilis he doubted whether better results were obtainable with calomel than with pills or inunctions.

M. BRISSAUD said he quite agreed with M. Leredde on the slight risks incurred in using large doses. At the same time with all his large experience he, like Professor Fournier, had had no satisfactory results. He admired people who could diagnose commencing general paralysis or early tabes; such diagnosis, in his opinion, were impossible. He thought that tabes had considerably changed of late years, whether due to the mercurial treatment of syphilis or no he was not in a position to say, but he desired to call attention to the fact that compared with past times the tabes described by Duchenne of Boulogne was much less frequently seen.

M. SEGARO said he had examined the cephalo-rachidian fluid in many cases of tabes, both before and after mercurisation, but had never found any modification in the meningeal lymphocytosis.

A. S.

CONTRIBUTION ON ACNE TELEANGIECTODES (KAPOSI).

WALTHER PICK. (*Archiv f. Derm. u. Syph.*, November, 1904, lxxii, p. 193.)

THE affection of the skin to which Kaposi gave the name of Acne teleangiectodes is the acnitis of Barthélemy. It has been identified with the Lupus follicularis disseminatus of Tilbury Fox, but the writer does not consider that they are identical.

In this contribution two cases are recorded.

Case 1 was that of a man, aged 65 years, and the eruption was present on the face, backs of the hands, extensor aspect of the arms, and on the penis. The

lesions were small papules about the size of a pin's head and were yellowish or brownish-red in colour. They were flat or rounded in shape and felt hard. A few of them had a translucent appearance, and when squeezed a drop of clear serum exuded. Some of them were covered with small scales of inspissated pus or a hæmorrhagic crust. When they involuted, smooth, slightly-depressed scars were left, which had a pigmented border and were somewhat similar to the scars of Acne varioliformis. The eruption was noticeably symmetrical in distribution, and chronic in its course. There was no evidence of tuberculosis in the patient. Tuberculin injection gave negative results, and also an inoculation experiment in a rabbit's eye with a piece of a lesion excised.

Case 2 was also in a male, and the forehead and cheeks were chiefly involved. The lesions were similar in appearance to those in the above case. The patient was otherwise healthy, and there were no signs of tuberculosis.

A microscopical examination was made in both cases, and gave similar results. The nodule was the result of focus of cellular infiltration, situated at first about the junction of the corium and subcutaneous tissue, with an intervening layer of healthy corium between it in the epidermis. As the focus increases in size it gradually comes to the surface and the epidermis breaks down. The component cells consisted of leucocytes, epithelioid cells, and numerous giant-cells. In the centre of several of the foci the cells had broken down and left an irregular space. The cells towards the centre of the focus, if present, stained badly. An examination for tubercle bacilli in sections gave negative results; 270 sections were examined for the bacilli.

After describing the cases the writer gave a critical survey of the literature on the subject, and comes to the following conclusions:

(1) Acne teleangiectodes is an entity and is not identical with Lupus follicularis disseminatus.

(2) It is identical with acnitis, but differs from folliclitis.

(3) There is no evidence that it is a tubercular affection, nor that it ought to be placed in the group of the tuberculides.

(4) It does not take its origin in the sebaceous glands, but may possibly have a connection with the sweat-glands.

J. M. H. M.

ON ACNE URTICATA. LUDWIG WAELSCH. (*Archiv f. Derm. u. Syph.*, December, 1904, lxxii, p. 349.)

THE name of Acne urticata was given by Kaposi to a series of cases in which a peculiar type of acne was present. The lesions began like wheals, and were associated with the most acute irritation, which caused the patients to scratch them and squeeze out the sero-purulent contents, by which means they obtained temporary relief. The lesions appeared first on the face, but later they appeared on the extensor aspect of the extremities. They varied in size from a bean to a kreuzer. The affection appeared to be a type of Acne vulgaris associated with an unusual degree of pruritus. In this contribution Waelsh described two cases, which he believed to belong to this category. They both occurred in females aged 25 years, and the lesions had been present for three and four years before they came under observation. The regions attacked were those mentioned by Kaposi. On the face, which was the part first affected, the lesions were most marked on the fore-

head, nose, chin, and lower part of the cheeks. The lesions somewhat suggested those described by Kaposi in their appearance and in the intense pruritus associated with them, but they were not follicular. [It is difficult to picture the eruption from the descriptions given, but there seems no reason for calling it an "acne," or for regarding it as similar to Kaposi's cases; the description suggests papular urticaria rather than acne.—ED.]

J. M. H. M.

ON THE PERSISTENT FORM OF ERYTHEMA NODOSUM. W. PICK.
(*Archiv f. Derm. u. Syph.*, December, 1904, p. 361.)

IN this paper the writer describes two cases in which lesions somewhat similar in character to those of Erythema induratum of Bazin occurred in the legs of two young women, aged respectively 17 and 19 years. In both cases the calf was the part chiefly affected, and the lesions consisted of subcutaneous nodules, some of which persisted, while others involuted. The histological changes present were confined to the subcutis, and consisted of a dense infiltration of round cells, especially located around the sweat-coils and blood-vessels. Many of these cells had spindle-shaped or oblong nuclei. Masses of them were present also in the septa between the fat lobes. According to the writer these cases showed a close analogy in their symptoms, localisation, and anatomy to the acute Erythema nodosum, and differed from the Erythema induratum (Bazin), which he believed to be a tuberculous manifestation on account of its histology, its reacting to tuberculin injections, and the facts that bacilli had been found by Philipppson, and inoculation in lower animals had given positive results.

J. M. H. M.

SCLERODERMA. HARVEY P. TOWLE. (*Boston Med. and Surg. Journ.*, December 8th, 1904.)

THE case was reported from the Massachusetts General Hospital. The patient was a female, aged 19 years, whose family and previous histories were negative. The disease had begun three years ago with sores on the knuckles and the ends of the fingers, which latter were cold, blue, and painful. These sores healed in a year, and then others appeared over the larger joints, which still persisted. Then the back and legs, and later the fingers and forearms, became stiff. Two years ago the skin became universally pigmented, and after nine months small white spots began to appear. The patient was much emaciated, and the elbows and knees could not be extended beyond a right-angle. The skin of the whole of the body was speckled brown and white, except the back, which was uniformly brown. The lighter areas were atrophied, but little, if at all, depressed. The white spots were most marked in the middle line of the part of the trunk. Over the wrists, elbows, knees, and many of the knuckles were wart-like crusted lesions on a reddened indurated base. She developed a gangrenous spot on the ball of the left big toe; the toes of this foot had previously been blue and painful, but had subsided. The lungs, heart, and urine were normal. Her general health, which at first was not much affected, gradually grew worse until she left the hospital. No treatment is mentioned.

G. S.

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A PLEA FOR THE MORE GENERAL USE OF TUBERCULIN BY THE PROFESSION.

BY SIR T. M'CALL-ANDERSON, M.D..

Regius Professor of Medicine in the University of Glasgow.

*The Oration delivered at the Annual Meeting of the Dermatological
Society of Great Britain and Ireland, May 24th, 1905.*

WHEN the Council of this Society on a former occasion did me the honour of inviting me to give the address at their Annual Meeting, I was reluctantly compelled, owing to the pressure of other work, to forego the pleasure of complying with their request. I am therefore very sensible of their kindness and consideration in again giving me an opportunity of doing so. For to me it is always a source of pleasure and satisfaction to meet my professional brethren, gathered together from different parts of the country, to discuss with them some of the knotty problems encountered in our daily work, and to learn from one another how these can best be solved.

My own interest in dermatology was first aroused in 1859, when, at Vienna, I sat at the feet of Hebra, who was at once one of the clearest, most interesting, and most attractive of clinical teachers, and one of the most genial of men. At that time the profession at large took little interest in the subject, and knew less: it looked upon specialities as the "abomination of desolation," while in England there were only two men whose names stood out as authorities—Startin, whose therapeutic acumen has left its mark upon the treatment of to-day, and

Erasmus Wilson, whose invaluable services to the science of dermatology will not soon be forgotten. When we institute a comparison with the position of to-day, what a contrast do we find! Specialities are no longer tabooed: we take pride in our *British Journal of Dermatology*, and in our special departments for diseases of the skin in all well-regulated general hospitals; while the country teems with expert dermatologists, and every large city has the benefit of the services of distinguished men, many of them of European reputation, who have added materially to our knowledge alike in its scientific and in its practical aspects.

I understand that this Society, besides many expert dermatologists, includes a considerable proportion of gentlemen who, while taking a deep interest in the study of diseases of the skin, are likewise engaged in general medical practice. It has therefore occurred to me that, in selecting a subject for your consideration, it might be well to take one which has not only an intimate connection with cutaneous therapeutics, but is also full of interest in the domain of general medicine. I propose therefore to refer to the value of tuberculin, in connection with which I had the honour of reading a paper at the Medical Graduates' College and Polyclinic about five years ago—for further experience of it has only served to confirm the opinion which I was then led to form of its valuable properties.

I have read with great pleasure Mr. Malcolm Morris's most interesting Harveian lecture on "Some New Therapeutic Methods in Dermatology," and one which is most valuable as epitomising the results of a long experience. I heartily agree with him in his observation with reference to chronic affections of the skin, in which he says: "I have been led to the conclusion that the general principle of treatment may be expressed in the single word reaction."

But my experience does not coincide with his remarks in reference to the use of tuberculin. "Any one," he says, "who had seen the violent reaction caused by Koch's tuberculin in its original form . . . on patches of *Lupus vulgaris* must have been struck by the change which came over the scene of disease when calm was restored. It looked as though at last Huxley's therapeutic ideal had been realised and it had 'become possible to introduce into the economy a molecular mechanism which, like a very cunningly contrived torpedo, shall find its way to some particular group of living elements, and cause an

explosion among them, leaving the rest untouched.' The hopes thus raised were doomed to speedy disappointment, for it soon proved that the 'torpedo' caused explosions not only in the places where cutaneous disease actually existed, but in hidden and—it might be—unsuspected points in vital organs like the lungs. Theoretically it was admirable, but it was not war in the therapeutic sense. The impossibility of limiting the reactive energy of tuberculin to the skin prevents in many cases the utilisation of the specific properties in the treatment of *Lupus vulgaris*." But, to my mind, this is one of its unique advantages. For we are thus enabled to attack and, in an early stage, to destroy unsuspected foci of disease in internal parts, before they have become a source of danger, illustrations of which will be given later on, and to prevent a re-infection of the skin at a future time.

When first introduced by Koch medical men tumbled over one another in their eagerness to obtain a supply of this preparation which was supposed to ring the death-knell of tubercular disease. The consequences were just what might have been expected: it was used too often in a reckless and indiscriminate manner, in cases altogether unsuitable, in doses too large and too frequently repeated and enlarged, thus leading to disappointment and disaster. Hence the extravagant laudation with which the discovery was hailed, and for which Koch was not responsible, soon gave place to an equally absurd depreciation of its merits, so much so that I think I am within the mark when I say that it finds no place in the armamentarium of the great majority of the medical profession. I have taken the trouble of looking over the indices of the last six volumes of the *Transactions* of this Society, and have failed to find the heading of "Tuberculin" in any one of them.

Like most other powerful remedies, it is useless or even hurtful if not administered with the requisite knowledge and skill. Having employed it continuously since its discovery, I have naturally come to know pretty well the most suitable class of cases and the precautions to be adopted in its use, while almost invariably cases of cutaneous tuberculosis have been benefited, and in many the manifestations have entirely disappeared.

No one is disposed to deny that the X-rays, and, above all, the Finsen light treatment have yielded admirable results, and constitute

a valuable addition to our therapeutic measures; but I am bound to add that there are many cases in which, from their situation or from their extent, they are unsuitable. Nor are we in a position to say—although the same remark applies also to the tuberculin treatment—that a relapse may not occur, especially if the general health is not attended to. For we must not forget that two factors have to be taken into account in dealing with tubercular disease—1st, the tubercle bacillus and its toxins, and 2nd, the soil favourable to its germination and development. So that, in order to obtain permanent results, it is obvious that, in addition to destroying the micro-organism, we must simultaneously adopt measures with the view of changing the soil upon which it flourishes; and that should be attempted by means of good and abundant nourishment, living in the open air, and the use of tonics, cod-liver oil, phosphorus, and other anti-strumous remedies.

With these preliminary observations I proceed to give a few illustrations of the value of tuberculin (1) in diagnosis, and (2) in treatment.

(1) *The Value of Tuberculin in Diagnosis.*

In considering the means to be adopted for the prevention of tuberculosis, one of the points naturally most insisted upon is the necessity for preventing the sale of tuberculous meat, and above all, of the milk of tuberculous animals; and with practical unanimity it is conceded that the injection of tuberculin is a very certain test of the presence or absence of tuberculous disease in them. How is it, then, that the tuberculin test is confidently relied upon for the diagnosis of tuberculosis in animals, while medical men who applaud its use in animals with rare exceptions fail to take advantage of it in the case of human beings when a doubt exists as to the diagnosis? It may possibly be due to the belief that, though useful in the case of animals, it is not to be relied upon or is not free from danger in man. But I can say, after having used it many thousands of times, that, with reasonable care, it is both safe and equally efficient in the human subject. Let me give you several illustrations.

CASE 1.—A boy (J. B—), aged 8 years, whose family and previous personal history were satisfactory, came under my care on July 4th of last year (1904) complaining of abdominal swelling and pain. His

illness commenced three months previously, with diarrhœa: he had four or five motions per day, which were fluid, rather offensive, and greenish, yellowish, or whitish in colour. The diarrhœa ceased about four weeks before admission; but two weeks prior to this the abdomen began to swell, and he complained of tenderness on pressure at its lower part. His appetite also failed, he lost flesh and colour, had a slight cough without expectoration, with occasional night-sweats, but no fever.

On admission the tongue was slightly coated, the appetite bad, and the bowels constipated, but there was no pyrexia. The abdomen was much distended, tense, and tender in the umbilical and hypogastric regions: the peritoneal cavity contained a fair amount of fluid. The examination of the lungs and other organs was negative.

There was no question that in this case the peritoneum was inflamed, and we know that most cases of chronic peritonitis in children are tubercular, but to make sure I tested it with tuberculin.

The first injection, on July 9th, 1904, of .25 c.c. of 1 in 1000 O.T. sent the temperature next day up to 104.4° , while the second, on July 16th of 0.75 c.c., resulted next day in a temperature of 103.2° . The question of the tubercular nature of the peritonitis being thus settled, the treatment with tuberculin was continued. He had between July 9th and October 4th twenty-two injections, the last strength being 1.5 c.c. of 1 in 10 with no reaction. Shortly after this, after having been shown to the members of the Glasgow Medico-Chirurgical Society, he was dismissed in perfect health, having gained 7 lb. in weight, notwithstanding the fever following most of the injections. I have at present in my wards another very similar case in which the result has been equally satisfactory. (Temperature chart shown.)

CASE 2.—On March 20th, 1903, a young woman (E. K—), aged 24 years, was admitted at the Western Infirmary suffering for two years from an ailment which was supposed to be Hodgkin's disease, and which set in after her second confinement. She was weak, emaciated, and pallid, and had numerous glandular enlargements, varying in size from a pea to a pigeon's egg, around the neck, in the left axilla, and to a less extent in the right inguinal region, swellings which commenced on the right side of the neck; they were hard and painless, and some of them confluent. Examina-

tion of blood—red corpuscles 4,850,000, whites 6,200 per c.mm. The former exhibited no change of shape, and no abnormal forms were seen. They stained well and equally with eosin, and the hæmoglobin equivalent was undisturbed. Leucocytes—polymorphonuclear relatively diminished. Hyaline cells of both varieties (medium and large) increased: no abnormal forms (*e.g.* myelocytes, etc.). The changes were in accord with those met with in Hodgkin's disease, but similar conditions are met with in other diseases (malaria, etc.) [Ferguson].

I suspected that these glandular enlargements might be tubercular, and as a test $\frac{1}{2}$ c.c. of 1 in 1000 tuberculin was injected, which in sixteen hours raised the temperature from 98.2° to 104° , while the glandular enlargements became tender, and there was some redness of the skin over them, thus settling the diagnosis. I may add that the tuberculin treatment was continued along with generous diet, phosphorus, and keeping the patient as much as possible in the open air, and the results were very satisfactory, as the glands became much reduced in size and the general health was re-established.

CASE 3.—On January 11th last a boy (J. W—), aged 10 years, was admitted on account of patches of eruption on left arm, on each buttock, under the right ear, and on the forehead, of four years' duration in all. During that time he has suffered from numerous patches of eruption of an indolent character and slow to subside. They have all been similar in character; they began as small spots, which spread circumferentially, attaining sometimes the diameter of 2", but without any round, abrupt, elevated edge. The colour of the patches was dusky-red, and most of them terminated by suppuration and crustation, but left very little in the shape of scars.

From the appearance of the eruption no one could be sure of its nature. I suspected at first that it was tubercular, all the more as a sister and several uncles and aunts were reported to have died of phthisis. But, on the other hand, on examination of the boy, who was rather thin, pale, and delicate-looking, the two upper central incisors presented the typical Hutchinson shape, and I ascertained that his mother had had five miscarriages, the first three before she had any living children.

These circumstances led me to the conclusion that my first supposition was incorrect, and that the eruption was probably based upon a hereditary syphilitic taint. But, in order positively to exclude tuber-

cular disease, he got two injections of tuberculin, the first of $\frac{1}{4}$ c.c., the second of $\frac{1}{2}$ c.c. of 1 in 1000. These were not followed by either local or constitutional reaction. (Unfortunately, patient's parents were going to England, and therefore removed the boy before anti-syphilitic treatment could be given.)

In the paper before referred to, and in other communications to medical societies, I have given other illustrations of the employment of tuberculin for purposes of diagnosis, and did time permit I could quote others by the dozen, because, as a matter of routine, it is always used in my wards in doubtful cases, so that there is no question that it is of *priceless value* in diagnosis, and it is therefore a surprise to me that it is not in general use by my professional brethren.

But, over and above this, it sometimes directs our attention to *unsuspected foci of tubercular disease*. Thus, in a case of lupus of the face, when the tuberculin was commenced, the patient began to complain of pain in the right elbow joint, and in a case of phthisis, in which the physical signs were limited to the left lung, moist râles appeared in the right mammary region. In these and similar cases, after three or four injections, the new symptoms lighted up disappeared: the tuberculin had ferreted out and destroyed unsuspected foci of disease.

(2) *The Value of Tuberculin in Treatment.*

CASE 4.—The first case is that of a disease with regard to which dermatologists are occasionally consulted owing to the discoloration of the skin which accompanies it—namely, Addison's disease, and which to me was deeply interesting. It was that of a married woman (E. P—), aged 31 years, who was admitted on May 9th of last year, complaining of great weakness, dyspnoea, and discoloration of the skin, symptoms of eighteen months' duration in all.

Her father and mother are alive and well, and, of a family of twelve, only four are alive, all the others having died in infancy with the exception of one who was said to have succumbed to tubercular meningitis.

Patient is married and has five children alive, one of whom suffers from enlargement of the glands of the neck. Shortly after her marriage she had an abortion at the third month. This was followed by a blood-stained discharge from the uterus, for which she was curetted with great improvement. At this time she was anæmic, and

continued so, never feeling well until 1902. In the month of August of that year she had a miscarriage at the sixth month, with much hæmorrhage. She was very ill at this time, and has never felt well since. Her menstruation, too, became very irregular as to time and amount, and she felt quite unfit for her household duties. A living child was born in September, 1903. From this time she felt very much worse, being exhausted on the slightest exertion.

State on admission.—She complains of an intense feeling of weakness and exhaustion, of want of appetite, constipation, headache, and pain across the loins, and of dyspnœa and palpitation on the slightest exertion. Her skin is deeply pigmented, a condition which is steadily on the increase. The buccal and conjunctival mucous membranes are pale; she is profoundly anæmic, and there is a venous hum in the vessels of the neck. But she is fairly well nourished, although she has lost 18 lbs. in weight since the onset of her illness. She has some bronchitis, with a few sonorous and sibilant râles throughout the chest. The urine is normal.

Blood examination.—Red blood corpuscles, 3,360,000 per c.mm.; white blood corpuscles, 3800 per c.mm.: hæmoglobin, 45 per cent. The red corpuscles are somewhat irregular in shape and size (slight poikilocytosis), and vary much in colour, showing wide fluctuations in hæmoglobin content, but there are no evidences of grave alteration of the blood. The appearances are those of a moderately severe secondary anæmia, and pernicious anæmia is definitely excluded.

For the last two years she has frequently suffered from weak turns, and has had several syncopal attacks, when she fell, although she has never entirely lost consciousness.

Owing to the fact that most cases of Addison's disease are the result of tubercular disease of the supra-renal capsules, I determined to treat her with tuberculin. The third injection was followed next day by a temperature of $100\cdot2^{\circ}$, and she then spontaneously complained for the first time of *pain in both hypochondriac regions*, opposite the supra-renal bodies, while, the day after the fourth injection (same strength, 1 c.c. of 1 in 1000), she again complained of deep-seated, dull pain in the same situations, while the temperature was $103\cdot4^{\circ}$. The dose was therefore not increased; indeed, after the eighth and last injection, the thermometer registered $104\cdot2^{\circ}$.

The first injection, of .5 c.c. of 1 in 1000, was given on May 25th,

the last on July 4th. On June 23rd the following report was made: Within the last fortnight there has been a marked change in patient's colour, as the pigmentation has almost entirely disappeared. She was now allowed up in the intervals between the injections, felt fairly strong and well, assisted the nurses in the ward, made the beds, etc. She also looked strong and well, and, as so often happens with hospital patients whenever their immediate troubles have disappeared, insisted upon leaving, although the course of treatment was not half completed, and I have not seen her since. I do not bring this case forward as an illustration of cure, but of notable improvement in a very short time of a disease which is the despair of the physician, and because, as far as I know, it is the first time that such treatment has been attempted. (Temperature chart shown.)

I now proceed to give a few illustrations of lupus similarly treated.

CASE 5.—A boy (E. K—), aged 14 years, was admitted on December 1st, 1903.

Condition on admission.—There was an extensive lupoid affection of the nose and upper lip, which were swollen, and a yellowish-green crust covered the top of the nose. There was also extensive antero-nasal ulceration of the same nature: the cartilage of the septum was perforated, and on both sides the inferior meatus was completely filled with organised granulation tissue. The right side of the upper lip was also ulcerated.

History of illness.—About six years ago, on recovering from a cold, he noticed that his nostrils remained blocked, but there was no pain, only some difficulty of breathing. From time to time yellowish crusts came away, giving temporary relief. Eighteen months later the tip of the nose became red, swollen, and glazed, and this condition slowly spread over the greater part of it. Nine months before admission the tip of the nose ulcerated, a crust formed upon it, and about this time the lip became affected.

Treatment.—During the first two years he seems to have been treated with various lotions and ointments, and then it was scraped and canterised in the Kilmarnock Infirmary, without benefit. In August, 1903, he went to the Electrical Department of the Western Infirmary of Glasgow, when the Finsen Light treatment was commenced, beginning with five minutes' exposure, with 10 ampères of current. The exposure was gradually increased to twenty minutes,

and the current to 12 ampères. This treatment was continued without benefit until December 1st, and then he was sent to my wards.

Tuberculin treatment was commenced on December 5th and continued till May 13th, the first injection being of 0·25 c.c. of 1 in 1000, and by March 26th 1 c.c. of 1 in 10 was injected, the usual maximum dose. He remained untreated until April 28th, when, as a precaution, he had five more injections, beginning with 1·5 c.c. of 1 in 1000, and ending on May 13th with one of 1 c.c. of 1 in 100.

On dismissal on May 18th he looked and felt very well, the external eruption was gone, the nostrils were healed, and were quite free (Temperature chart shown.) See Fig. 1 "After treatment."

CASE 6.—A boy (C. M—), aged 14 years, was admitted into the Western Infirmary of Glasgow on March 15th, 1904.

Condition on admission.—The central portion of the right ala nasi is eroded, and the remainder is cicatrised. The lower half of the nose in front and on the left side is eaten away, thickened, and livid, and covered with fine scales, while the margin is fairly well defined. The entire left ala nasi and neighbouring portion of the nose is ulcerated, and covered with greenish-brown crusts. The nostrils are much blocked, especially on the right side, with granulation tissue and crusts. The central portion of the upper lip, down to the edge of the mucous surface, is ulcerated, the margins being well defined. The whole surface uncovered by crusts has a violet tint. There are two typical lupoid ulcers on the right arm.

History of illness.—The eruption began about 2½ years before admission, when a small raised spot appeared on the left forearm, which ulcerated, and a crust formed. A week or two later a spot, similar to the first, appeared about one inch further up the arm, which ran a similar course. The surrounding skin has gradually become thickened and reddened, and slightly scaly. These patches have slowly extended, but are very insensitive. Shortly after the appearance of the eruption on the arm he noticed a small scab on the right side of the nose, and from thence the disease slowly spread till it reached the dimensions present on admission. When 7 years of age he suffered from disease of the left tibia, which was probably tubercular, and a brother died at the age of 20 from tubercular disease of the spine.

Treatment.—On November 6th, 1902, X-ray treatment was commenced in the Electrical Department of the Western Infirmary, and

continued daily for ten minutes until December 20th; but as there was no improvement the boy ceased attending.

When admitted to my department on March 15th, 1904, it was determined to use tuberculin. He had 40 injections in all, the first of 0.25 c.c. of 1 in 1000, on March 19th, the last, of 1 c.c. of pure tuberculin, on September 6th.

This patient made an excellent recovery, and long before the tuberculin treatment was stopped he was quite well. His weight on admission was 5 st. 10 $\frac{3}{4}$ lb., and when he left the hospital 6 st. 9 lb. (Temperature chart shown.) See Figs. 2 and 3, "Before and after treatment."

CASE 7.—A young woman (L. C—), aged 18 years, was admitted to the Western Infirmary of Glasgow on February 22nd, 1904. Family and previous personal history excellent. Four years ago a "soft pimple" appeared on the middle of the bridge of the nose, which slowly increased in size, and broke down, leaving an ulcer covered with a greenish crust. The ulceration went on extending, while the surrounding skin was elevated and dusky-red.

A year after the onset the ulceration was scraped at the infirmary at Stirling, and healing took place; but the disease soon reappeared, and spread to the point of the nose and to the right ala nasi, subsequently involving the right side of the upper lip. At the close of the second year it was again scraped, but with only temporary improvement, for the ulceration soon reappeared, and involved also the left ala nasi, while the right nostril was obstructed.

Condition on admission.—The whole of the lower half of the nose, the right side of the upper lip, and the septum nasi are covered with greenish-yellow crusts, on removing which the parts are seen to be ulcerated, soft, and boggy.

Treatment.—First injection of tuberculin, $\frac{1}{2}$ c.c. of 1 in 1000, on March 6th, sent the temperature up to 103° next day, while the second, on the 15th, was followed by a temperature of 105°! and on each occasion inflammation occurred at the seat of the disease, with exudation, the surrounding parts being the seat of redness and swelling. Subsequent injections led to decreasing reaction, until at last there was none at all. She had 32 injections, the last on July 31st, when the strength was 1 c.c. of pure tuberculin.

This patient recovered perfectly, there being only slight scars and

very little deformity, and on dismissal she looked and felt quite well, and had gained nearly a stone in weight. (Temperature chart shown.) See Figs. 4 and 5, "Before and after treatment."

CASE 8.—A girl (L. G—), aged twelve years, came under my care on February 18th, 1904, suffering from scrofuloderma of the arms of three years' duration.

The only flaw in the family history is that a paternal aunt died of phthisis, and her own previous history is satisfactory.

History of illness.—Three years before admission a small round red spot, without pain or itching, appeared on the outer side of the right elbow, which gradually spread, and when it had reached the size of a penny it became soft, ulcerated, and crusted. By and by it began to heal in the centre, while only the rounded edge was crusted. A year later a similar eruption appeared on the back of the right hand, and continued extending until the whole of the back of the hand was involved. About the same time a similar lesion was observed above the left breast, which, however, disappeared in four or five months, leaving a white scar. Six months before admission the disease attacked the inner side of the left forearm and spread rapidly, healing in the centre and extending at the edges, and a patch also made its appearance on the outer side of the right arm.

Condition on admission.—She is pallid, delicate-looking, and thin, weighing 5 st. 8 lb. The back of the right hand is covered with a thick crust, as well as the patch higher up on the arm, while those on the elbow and on the left arm are mainly crusted at the edges. They have a tendency to heal in the centre and to spread at the edges, which are violet-coloured, the adjacent skin being soft and boggy to the touch. There is neither pain nor itching, but at the healed parts there is much destruction of tissue, and the cicatrices are of a blue-white colour.

The first injection, of $\frac{1}{4}$ c.c. of 1 in 1000, was given on February 27th, and she had 42 injections at intervals of about four days, the last, of 1 c.c. of pure tuberculin, on August 13th.

On dismissal, her appearance and general health left nothing to be desired. She was plump and fresh-looking. All the lesions were healed, the scar-tissue remaining being soft and pliable. (Temperature chart shown.) See Figs. 6 and 7, the latter having been taken six weeks before the treatment was stopped.

The following photographs of patients who had been affected with lupus, taken before and after tuberculin treatment, further illustrate the value of the remedy.

At an early period of my professional life I came to the conclusion—contrary to a very general opinion at the time—that *Lupus vulgaris* is a manifestation of the tubercular diathesis, a view which is now generally admitted. But I also held, and still hold, that the true *Lupus erythematoses* is also a member of the same family. I freely admit, however, that few will agree with me in this opinion. Time will not permit of my discussing this subject at present, but this I may say, that one of the arguments used against this view is that *Lupus erythematoses* does not react to tuberculin. But is the statement correct? That some cases do not respond I grant you, but many of them do, in proof of which let me refer shortly to two cases by way of illustration.

CASE 9.—A woman (M. S—), aged 31 years, was admitted November 24th, 1896. The family history was not satisfactory: one brother died of what was supposed to be “bronchitis,” and one from “pleurisy,” while her father and aunt on her father’s side died of consumption.

At the age of 17 she received an injury to her nose, six months after which a dusky red erythematous spot appeared upon the left ala nasi and gradually spread downwards and across the nose to the right side. Eight years afterwards a similar spot appeared on the left cheek and spread more rapidly.

Condition on admission.—The eruption involves almost the entire surface of the nose, and there is a large patch on the left cheek. The eruption is erythematous, without moisture or ulceration, violet in colour, and with clearly demarcated rounded edges.

Tuberculin treatment was commenced on December 7th; the fourth injection, on December 13th, of 1 c.c. of 1 in 1000, sent the temperature up to 104° , while the following one on the 17th raised it to 102.6° . After this the reactions became less pronounced, and after the 30th there was no rise of temperature, although the strength of the injections was steadily increased. She had thirty injections in all, the last on February 15th, 1897, of 1 c.c., full strength. On March 16th she was dismissed well, there being little scarring. (Temperature chart shown.)

CASE 10.—A girl (J. F—), aged 18 years, entered my department on November 30th, 1896, four days after the patient whose case has just been referred to. Family and previous personal history satisfactory as far as known.

History of illness.—Eruption began two years before admission as a red blush on the side of the nose which gradually spread to the other side and ultimately involved almost the whole of the face. Thereafter the ears, hands, and forearms became similarly implicated, and lastly the head.

Condition on admission.—She is a delicate, weakly girl, but there is no evidence of disease except on the surface. The eruption has a livid colour, with abrupt edges, circular in parts. It occupies the whole of the face except the forehead, but there is a small patch on the left parietal region. Patches of eruption are also observed on the ears, head (with loss of hair), backs of the hands, and outer aspects of the forearms. There is little tendency to desquamation.

Tuberculin treatment was commenced on December 7th, 1896, in doses similar to those in the last case. The first injection resulted in a temperature of 100° , the third of 102° , the fourth of 104° , and the fifth of 104.2° , after which the reaction steadily declined. There were twenty-two injections in all, the last being on February 24th, 1897. She was dismissed well on March 12th.

In all cases, in addition to tuberculin treatment, the general health was carefully attended to. Cod-liver oil, or phosphorus, was administered, with generous diet, and the patients were kept as much as possible in the open air, except when there was fever as the result of the injections. In every case, and in most of the others which I have treated, the old tuberculin was used.

Allow me, in conclusion, to make a few observations in reference to the carrying out of the tuberculin treatment, as those who have not been in the habit of using it may wish to employ it. When injected, it ferrets out and attacks ALL tubercular foci, even bringing to light some of which there had been no previous suspicion. If we study its action in the case of external tuberculosis—and no doubt similar changes take place in internal parts—we observe not only constitutional reaction and fever, but also redness, swelling, and often exudation and crusting at the seat of the disease, and in this way the morbid tissue is destroyed. What we should aim at, therefore, is to

LUPUS VULGARIS OF 6 YEARS' DURATION.

AFTER TREATMENT.



FIG. 1.

EDWARD KINNEY, AET. 14, ADMITTED DEC. 1, 1903.

Tuberculin Injections :—1st Injection. .25 c.c. of 1 in 1000. Old Tuberculin, Dec. 5, 1903.

Last Injection. 1 c.c. of 1 in 100.

Number of Injections, 36.

LUPUS VULGARIS OF 2½ YEARS' DURATION.

BEFORE TREATMENT.



FIG. 2.

CHARLES MCCARTNEY, ÆT. 14, ADMITTED MARCH 15, 1904.

Tuberculin Injections:—1st Injection. "25 c.c. of 1 in 1000. Old Tuberculin, March 19, 1904. Last injection. 1 c.c. of Pure Old Tuberculin, Sept. 6, 1904.
Number of Injections, 40.

AFTER TREATMENT.



FIG. 3.

LUPUS VULGARIS OF 4 YEARS' DURATION.

BEFORE TREATMENT.



FIG. 4.

LIZZIE CAMPBELL, ÆT. 18, ADMITTED FEB. 22, 1904.

Tuberculin Injections :—1st injection, .5 c.c. of 1 in 1000. Old Tuberculin, Mar. 6, 1904. Last injection. 1 c.c. of Pure Old Tuberculin, July 31, 1904.
Number of Injections, 31.

AFTER TREATMENT.



FIG. 5.

SCROFULODERMA OF 3 YEARS' DURATION.

BEFORE TREATMENT.



FIG. 6.

AFTER TREATMENT.



FIG. 7.

LIZZIE GORDON, AET. 12, ADMITTED FEB. 18, 1904.

Tuberculin Injections.—1st Injection. 25 c.c. of 1 in 1000. Old Tuberculin. Feb. 27, 1904. Last Injection. 1 c.c. of Pure Tuberculin. Old Tuberculin, August 13, 1904.
Number of Injections, 42.

LUPUS VULGARIS.

DEC. 5, 1901. BEFORE TREATMENT.



FIG. 8.

FEB. 20, 1903. AFTER TREATMENT.



FIG. 9.

MAGGIE WILSON, ÆT. 20, ADMITTED DEC. 2, 1901.

Tuberculin Treatment.

LUPUS VULGARIS.

FEB. 26, 1902. BEFORE TREATMENT.



FIG. 10.

MAY 7, 1902. AFTER TREATMENT.

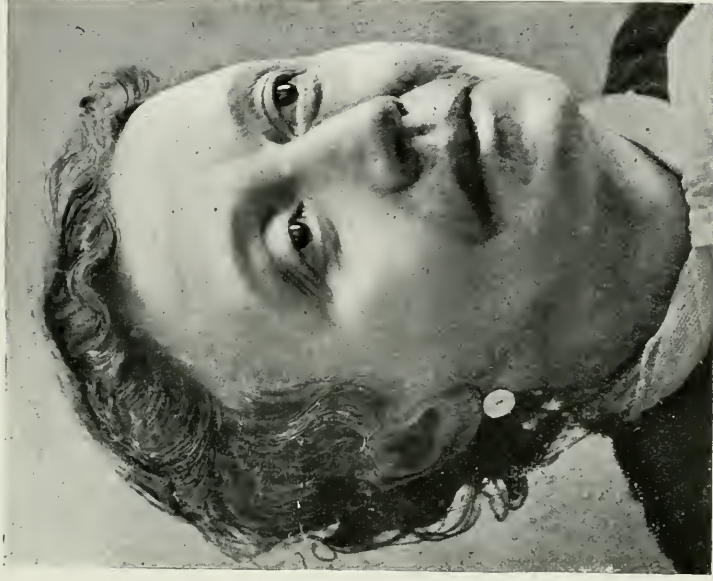


FIG. 11.

GERTURDE BALTRAN, Æt. 52, ADMITTED FEB. 23, 1902.

Tuberculin Treatment.

LUPUS VULGARIS, 5 MONTHS' DURATION.

BEFORE TREATMENT.



FIG. 12.

AFTER TREATMENT.



FIG. 13.

JOSEPH HIGGINS, ÆT. 14, ADMITTED SEPT. 12, 1904.

Tuberculin Treatment :—1st Injection, $\frac{1}{4}$ c.c. of 1 in 1000. Old Tuberculin, Sept. 22, 1904. Last Injection. 1 c.c. of Pure Old Tuberculin, Feb. 17, 1905.

produce well-marked local reaction with as little fever as possible, because, while the former is essential, the latter is rather injurious than otherwise. In carrying out the treatment the following rules should, in my opinion, be observed :

(1) The initial dose of the old tuberculin, in the case of an adult, should not generally exceed $\frac{1}{2}$ c.c. of 1 in 1000, and sometimes it is safer to begin with $\frac{1}{4}$ c.c.

(2) If a given dose yields little or no result, it is usually safer to give a second of the same strength as the last, because the latter often acts much more severely than the former, of which many illustrations are afforded by the charts which have been inspected.

(3) The more pronounced the constitutional reaction the longer should the interval be before the following injection, an interval of several days of apyretic temperature at all events.

(4) Much greater care must be exercised in increasing the doses at the earlier than at the later periods of the treatment, because the system gradually gets acclimatised to it, so much so, indeed, that, while an initial dose of $\frac{1}{2}$ c.c. of 1 in 1000 may raise the temperature to 103° or 104° , the final dose—say of 1 c.c. of pure tuberculin—may have no result at all.

In directing your attention to this subject, gentlemen, do not suppose that I have any wish to minimise the value of other methods of treatment, above all, that of the Finsen light, which is undoubtedly a very valuable addition to our therapeutical resources. On the other hand, an extended experience has led me to the conclusion that the armamentarium of the practitioner is incomplete if, in dealing with tubercular affections, it does not include the use of tuberculin, whether regard be had to questions of diagnosis or of treatment. Besides it must never be forgotten that we are not all built upon the same mould, and that treatment suitable and efficacious for some patients is useless or even injurious in the case of others. And there can be no question that there are many cases of tubercular disease for which, from their *situation* or from their *extent*, the light treatment is inapplicable, whereas neither situation nor extent contra-indicate the treatment which has formed the subject of this communication.

SOCIETY INTELLIGENCE.

THE DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.

DISCUSSION ON PROFESSOR M'CALL-ANDERSON'S ORATION.

THE PRESIDENT remarked that the case of tuberculous peritonitis narrated by Professor M'Call-Anderson was unique. He was also glad to hear of the success in the treatment of so grave a malady as Addison's disease with tuberculin.

Dr. GRAHAM LITTLE said he was particularly interested in hearing the paper which had just been read. In conjunction with Professor A. E. Wright (whom he hoped would have been present) he had been pursuing a similar line of treatment, not so much from the point of view of diagnosis as for therapeutic purposes. He had, however, not employed the old tuberculin, but the new, with which he had experienced no bad reaction at all. Dr. Little showed a case of *Lupus vulgaris* in a woman, of eighteen years' standing, who had been given injections of the new tuberculin by Professor Wright at St. Mary's Hospital at intervals of ten days. He had watched her for the last eighteen months, and the change in her appearance was phenomenal. She had put on flesh, and the dry patches upon the face had much improved.

Dr. A. J. HARRISON referred to the time when he employed the old tuberculin in the Bristol General Hospital. He had then been somewhat discouraged by the severe reaction which had followed the treatment in many cases.

Dr. R. L. BOWLES expressed a hearty vote of thanks to Professor M'Call-Anderson for his valuable address, to which he had listened with real pleasure. It was of especial interest at the present time, when so many other different methods of treatment for cutaneous and other forms of tuberculosis were in vogue. He had seen in Berlin the severe reaction after the old tuberculin, but he considered that the reader of the paper had brought before the whole profession the necessity for a thorough reconsideration of the question. In those cases where X-rays had proved disappointing it was quite possible that the use of the new tuberculin might be found beneficial after further experience.

THE NETHERLANDS SOCIETY OF DERMATOLOGY.

THIS Society, we are glad to observe, continues its active career. The fifteenth general meeting was held on Sunday, December 20th, 1903, in Amsterdam, under the presidency of Professor S. MENDES DA COSTA.

At this meeting the PRESIDENT himself demonstrated several cases of clinical interest, specially certain cases in which the X-rays had been used for the purpose of the amelioration of carcinomatous tumours, certain cases of syphilitic lesions and a case of myxœdema in a girl aged 11 years.

Mr. VAN DUGTEREN also showed cases undergoing treatment by means of radium, and discussed the relative value of different methods of radio-therapy.

The greater part of the record is taken up by the discussion following a paper by Mr. SCHOONHEID upon the effect of syphilis upon the circulatory apparatus.

Mr. H. BRONGERSMA, in conclusion, gave an account of certain cases of tumour of the bladder under his observation and the results of treatment.

The *Sixteenth General Meeting* was held on Sunday, May 29th, 1904, at Amsterdam, under the presidency of Dr. TELJER.

The PRESIDENT brought forward a case of multiple sarcoma of very wide extent.

Mr. BROERS brought forward two cases of "ichthyosis localis," occurring in two girls, aged 4 and 7 years, and discussed the relationship of this condition with general ichthyosis and other forms of imperfect keratisation.

Two interesting cases of the dermatitis herpetiformis group were brought forward by Mr. VANDERHOOP. One of these was an example of hydroa gravidarum, and in relation to this Mr. TELJER described a case of herpes gestationis recently under his observation, and discussed certain points in its symptomatology.

The latter part of the meeting was occupied by a paper by Mr. MENDES DA COSTA on the alterations of the skin produced by errors in metabolism.

After review of the subject and mention of the conditions usually related to errors in metabolism, he placed the following proposition before the Society, viz.: Is any member of the Society aware of a disease of the skin directly caused by metabolic error? As an example the tophus due to gout may be taken as a definite lesion due to metabolic error, though it would hardly be correct to classify the formation of tophi as a disease of the skin.

Messrs. SPRUYT LANDSKROON, WENNIGER, SCHOONHEID, and BROERS took part in the discussion.

Report of Seventeenth General Meeting, held on December 11th, 1904.

President, Dr. TELJER.

Mr. MENDES DA COSTA presented: (1) The sister of the patient spoken of at the previous meeting, suffering from *Ichthyosis fetalis*. The young woman was 19 years of age, and showed the condition in a slightly less severe degree than her brother. No other members of the family were affected, but both the patients were eight months' children.

Mr. DA COSTA did not consider that there were sufficient reasons for distinguishing *Ichthyosis vulgaris* and *Ichthyosis fetalis* as separate diseases.

(2) A girl, aged 3 years, suffering from *multiple ecchymosis*, produced by the least injury.

(3) A case of *exfoliation*, following *Erythema scarlatiniforme*, provoked by the administration of antipyrin.

(4) A case of *Diabetic gangrene*.

(5) A case of *Dermatitis exfoliativa*.

Mr. BROERS showed an early case of *Xeroderma pigmentosum*. The lad was 13 years of age, and had been brought to Mr. Broers with the characteristic statement that the least exposure to sun produced the eruption. In the words of his father: ". . . wat den jongen scheelt weet ik niet maar hij kan het zonnetje niet hebben."

The eruption was now in the early stage, showing itself principally on the face, the ears, the hands, and the uncovered parts as brownish-red, thickened, and roughened patches. The covered skin seemed to be unaltered.

The parents had no blood-relationship with each other, and no other member of the family, though there were eight children, showed any appearance of the disease.

Mr. Broers discussed the character of the lesions and the progress of the case, and had finally to defend himself against many criticisms as to the diagnosis he advanced, but finally held to the diagnosis he had originally suggested.

Mr. MENDES DA COSTA brought forward cases of *exfoliation* after administration of antipyrin, of *Diabetic gangrene*, and of *Dermatitis exfoliativa*, and later brought forward cases of *Lupus* treated by various methods.

Mr. MENDES DA COSTA also opened a discussion giving his experiences on the sterilisation of the insoluble preparations of mercury for hypodermic injection.

A case of *sporadic cretinism* in a girl, aged 18 years, was shown by Mr. MUIJS, who described the treatment he had adopted by means of powdered thyroid gland.

Pathological preparations of a *cystic tumour* of the forearm was shown by Mr. MENDES DA COSTA, of *sarcoma* by Messieurs TELJER and SCHOONHEID, and Mr. MENDES DA COSTA finally gave a report of his attendance at the Berlin Dermatological Congress.

J. G

CURRENT LITERATURE.

ON SYRINGOM. J. CSILLAG. (*Archiv f. Derm. u. Syph.*, November, 1904, p. 175. Two plates.)

A LARGE variety of names have been from time to time applied to the peculiar affection of the skin which forms the subject of this paper. Among them the most common are "*Lymphangioma tuberosum multiplex*," "*Hæmangio-endothelioma*," and "*Nævus cystepitheliomatodes*." Just as the various writers on the subject differ as to the most appropriate name for the disease, so they are also at variance with regard to its real nature. Kaposi, Lesser-Beneke, and Elschnig believe the lesions to be endothelial tumours arising from the endothelium of the lymphatics of the skin; Jarisch, Wolters, and others think that they take their origin in the endothelium of the blood-vessels; and other writers, such as the

author of the paper, believe that they arise from the epithelium. One of the most recent communications on the subject was by v. Waldheim in 1902, and he adopted the last view.

In this paper the writer describes the clinical appearances and histology of half a dozen cases of this affection. Three of the cases occurred in women and three in men, and all the patients were young adults. In all the cases the eyelid was the region affected; in one only were there lesions present elsewhere on the skin. The lesions were similar clinically in all the cases, and consisted of small hard tumours varying in size from a poppy-seed to a hemp-seed, irregularly round in shape, and exhibiting various shades of colour from yellowish white to brownish. The surface of the lesion was flat and shiny.

The histological characteristics were similar in the pieces of tissue examined, and were somewhat allied to those described by Brooke in "Epithelioma adenoides cysticum." The most noticeable histological feature was the presence of processes growing down from the surface-epidermis and formed of rows of cells. These rows occupied the middle zone of the corium. They ended in various ways, some indefinitely in the lymphatic spaces, others in colloidal cysts, while a third variety terminated in a cluster of epidermal cells concentrically arranged. Here and there cysts or concentric groups were present which had no apparent connection with the processes. In the majority of the cysts a layer of cells was present which contained granules resembling keratohyalin. The cells forming the rows were round or oval in shape and had lost their prickles. In a few of the cysts horny masses were present. The cells of the basal layer of the epidermis were deeply pigmented. The subpapillary capillaries were dilated, but there were no destructive changes present in the corium. In none of the sections were there blunt processes with a lumen such as have been described by Philippson, or any suggestion of sweat-gland formation as was noted by Blaschko and Neumann in their cases. The writer found that the growth took place almost entirely from the surface-epidermis, and only rarely was a sweat-duct or a hair-follicle connected with it.

J. M. H. M.

ON THE ABSORPTION OF IODINE OUT OF IODIDE OF POTASSIUM OINTMENT. HIRSCHFELD and POLLIO. (*Archiv f. Derm. u. Syph.*, November, 1904, lxxii, p. 163.)

IN 1900 in Kaposi's *Festschrift* Lion published a paper from the Breslau Dermatological Clinic on the capacity of being absorbed of iodide of potassium in ointments. As a result of his experiments he found that absorption of the iodide occurred in a 10 per cent. iodide of potassium ointment with vaseline as the base, provided a considerable quantity of the ointment were employed—as much as 50 grm., but if lanoline were used instead of vaseline as the base or small quantities of the potassium-iodide vaseline ointment employed, then no absorption took place. He found that the absorption occurred in macroscopically intact skin of man and animals. The absorption of the iodide was determined by an examination of the urine and sputum. Lion believed that the iodide of potassium was absorbed, but not in the form of free iodine. The experiments detailed in this communication in the main corroborate Lion's conclusions, but differ in certain details. Hirschfeld and Pollio found that the iodide of potassium broke up, and that it was free iodine which was absorbed. They had the same experience with lanoline

as Lion, finding that if the iodide were incorporated with lanolin or resorbin no absorption occurred, but if 10 per cent. olive oil or vaseline were added to the lanoline, iodine could be detected in the urine. They also found that it was not necessary to employ a large mass of the ointment for absorption to occur, but that 2 or 3 grms. applied to the inner surface of a limb was all that was required. They also noted that when salicylic acid or salicylate of sodium were added to the ointment the acid could not be detected in the urine.

J. M. H. M.

ON THE ABSORPTION OF IODINE OUT OF IODIDE OF POTASSIUM OINTMENT. A. HEFFTER. (*Archiv f. Derm. u. Syph.*, November, 1904, lxii, p. 171.)

IN a short communication with the above title the writer describes an experiment which was carried out on one of Professor Jadassohn's patients at Berne. An ointment containing sodium bicarbonate and iodide of potassium, of each 10 per cent. in vaseline, was continuously applied to the skin. In three hours iodine was found in the urine. No free iodine was detected on the surface of the skin. The freeing of iodine in the organisms was believed to be due to the action of nitrites, which, by becoming oxidised, liberated the iodine. Nitrites are present in the sweat, and if the reaction of the sweat be acid they are capable of freeing the iodine. The sebum has also the same power. In the skin, however, free iodine is not detected, as it has a close affinity for the protoplasm of the cells, and unites with it to form an albuminate.

J. M. H. M.

A CONTRIBUION TO OUR KNOWLEDGE OF SARCOMA IDIOPATHICUM MULTIPLEX HÆMORRHAGICUM (KAPOSI). A. HALLE. (*Archiv f. Derm. u. Syph.*, December, 1904, lxxii, p. 373.)

FOUR cases of Sarcoma idiopathicum multiplex hæmorrhagicum, which occurred in Professor Riehl's clinic in Vienna, are reported in this paper. The first was that of a man, aged 69 years, and the lesions were present over the whole skin, but were most numerous on the extremities, and consisted of tumours varying in size from a pea to a walnut and presenting a violet tinge.

Case 2 also occurred in a male, aged 64 years. The disease had begun four years before this report was made, as dark pigmented spots on the back of the right hand and foot. Gradually a raised pseudo-œdematous patch about the size of a five-shilling-piece developed on the back of the left hand, and other foci of the disease appeared about the fingers and trunk. The skin on the affected hand and fingers was reddish-brown in colour and atrophic. The disease showed a tendency to spread up the forearm, and the glands about the elbow became enlarged. The case was discharged without any improvement having resulted from his hospital treatment.

In Case 3, which was a male, aged 58 years, the feet were symmetrically affected, the skin being bluish-red in colour and covered with numerous tumours. The legs were also implicated. In the treatment of this case X-rays were tried with considerable benefit. After the exposure to the rays no new lesions developed and those present improved.

In Case 4 the patient was a male, aged 69 years, whose feet were symmetric-

ally affected. The toes were plump and thickened, and presented a dark blue tinge. On the legs there were numerous typical nodules. The skin of the abdomen was infiltrated in patches, and the lymph-glands were enlarged. As in Case 3 the penis was affected.

After describing these cases the author refers in detail to the literature on the subject. He believes the disease to be a special form of Sarcomatosis cutis, and not simply an inflammatory infiltration. He considers that it primarily affects the blood-vessels and the lymph-channels, and is possibly produced by some toxin apart from or associated with the influence of temperature.

J. M. H. M.

THREE CASES OF PRURITUS DUE TO TOBACCO. BOTTSTEIN.

(*Monats. f. prakt. Derm.*, November 15th, 1904, p. 577.)

THE first case was that of a man who was a teetotaler and moderate in his living. No other cause than tobacco-smoking could be found for his pruritus, and this disappeared when he gave up smoking.

The second case was also a man, and he had been in a private hospital for stomach trouble, but started smoking again when he left. Two days after the first smoke intense itching of his whole body set in, increased in intensity, and robbed him of his night's rest. The patient states that once before, after smoking too much, a similar irritation set in. Cessation of smoking caused the skin trouble to disappear, but it started afresh after any return to tobacco. It may be remarked that the irritation was slightest after cigars, worse after cigarettes, but worst of all after smoking a short pipe.

The third patient was also a man, and had pruritus of the scrotum and perineum occurring twelve to twenty-four hours after smoking a pipe, but not after cigars. The pruritus disappeared when smoking was given up.

Bottstein does not state whether he is himself a smoker.

J. L. B.

RICHTER'S TONOGEN SUPRA-RENALE. POROSZ. (*Monats. f. prakt.*

Derm., December 1st, 1904, p. 647.)

THIS is a preparation of supra-renal extract, made as follows:

Water.	100
Supra-renal extract	0.10
Chloretone.	0.50
Sodium chlorate	0.70

Porosz finds it to be in many cases an excellent preparation for producing constriction of vessels, diminishing secretion, and causing an anæsthetic effect. In urological work he has used it with great success, in gonorrhœa he uses a 5 to 10 per cent. solution of the original 1 in 1000 preparation, in post-bleorrhagic catarrh a 1 to 2 per cent. solution, and in hypertrophied prostate and urethro-cystitis it also acted well.

J. L. B.

A CASE OF MYCOSIS FUNGOIDES. ULLMANN. (*Monats. f. prakt. Derm.*,

December 1st, 1904, p. 631.)

THE patient was a man, aged 67 years, who had been treated without success for five years previously in Trapani, a provincial town of Sicily. The first

symptom of the disease appeared as a small dark-coloured patch on the left external malleolus, with swelling above the ankle, but no pain. More patches appeared, and the left inguinal glands became enlarged. Induration appeared four years after the commencement of the disease on the back of the left thigh. Five months ago, on positions where patches and then induration had been, there developed nodular growths. Exudation followed over some of these growths, and also marked itching became noticeable. Three years ago a tumour appeared over the trachea beneath healthy skin, and developed very slowly.

When examined, he was found to have arterio-sclerosis and emphysema. The left leg showed changes such as are seen in chronic, badly-treated eczema, the skin being covered with crusts and scaly patches, infiltrated and resembling elephantiasis. Bluish-red, sometimes circumscribed patches, and œdematous lesions were also present. On the left thigh were also changes resembling those of eczema, and also twelve tumours the size of a pea to an apple, some pedunculated, some sessile, of an elastic feel. In the left inguinal region were similar tumours, and also infiltrated and eczematous lesions. Few changes were present on the right leg. The skin of trunk, face, and upper extremities was normal.

The diagnosis was open to no question, but it was interesting to see the various stages of the disease—eczematous plaques, erythematous patches, infiltrated lesions of the second stage, and fungating tumours of the third stage—all existing side by side.

A piece of one of the smaller tumours was excised, and one half hardened in absolute alcohol, the other half in sublimate and then alcohol, and then imbedded in celloidin. Sections were stained in various ways. The cells of the epidermis showed no pathological changes. The stratum corneum was in places thickened, the corium appeared to be the origin of the diseased process. The blood- and lymph-vessels were somewhat dilated, the connective-tissue fibres separated and pressed apart by masses of polymorphic cells, rich in collagen. These cells appeared to be derived from the connective tissue and resembled those seen in granulation tissue; plasma-cells and giant-cells were absent, mast cells were few, and Unna's horny masses numerous. The elastic fibres were unchanged, and leucocytes were not to be found.

J. L. B.

SKIN CHANGES IN KIDNEY DISEASE. JORDAN. (*Monats. f. prakt. Derm.*, December 1st, 1904, p. 637.)

DURING his ten years of dermatological experience Jordan has only seen a few cases which could be called albuminuric dermatoses. In private practice two cases of pruritus and two of general furunculosis, in hospital work two cases of eczema and one case of gangrene in individuals with large or small amounts of albumen in the urine is no great number, but in some of these cases, especially in the private cases, the finding of albumen came as a surprise, and but for the skin affection might have passed unnoticed. In all the four private cases the administration of mineral waters, which acted upon the kidneys, caused a disappearance of the skin affections.

Of the hospital cases, one was a smith, aged 73 years, who had emphysema and bronchitis, as well as excoriations and pustules on the backs of the hands and

legs, which pointed to pruritus. There was also œdema and bluish-red pigmentation of the dorsa of the feet. The urine of the twenty-four hours amounted to 7000 c.c., and contained albumen, but no sugar.

Seven days afterwards an unpleasant swelling abscess was opened on the left foot, the floor of which looked blackish and discoloured. The next day a smaller gangrenous patch appeared on the right leg, and was opened. Eczematous lesions in various positions were treated and gradually improved, as also did the gangrene, and the patient left the hospital five weeks after admission greatly improved.

The second patient was a girl, aged 15 years, with eczema, who was treated with urotropin, baths, dieting, and zinc ointment, but only improved gradually.

The third patient was a woman, aged 26 years, with nephritis gravidarum and eczema, in whom the twenty-four hours' urine only amounted to 600 c.c., with $\frac{1}{2}$ per cent. albumen and some cylindrical casts, but who improved considerably under treatment.

These cases showed improvement of their skin condition only when the kidney trouble was treated, and Jordan discusses the question whether there really is such a thing as a group of albuminuric dermatoses and whether the occurrence of skin-diseases in individuals with diseased kidneys is sufficient to warrant such an assumption. It is true that more especially furunculosis and gangrene are common complications of glycosuria and are by some held to be due to the glycosuria, and it is possible to argue that the same skin affections, as also eczema, urticaria, purpura, etc., may be caused by albuminuria or kidney disease. But there are usually two sides to such arguments.

J. L. B.

GRANULOMA PYOGENICUM (BOTRYOMYCOSIS OF FRENCH AUTHORS). M. B. HARTZELL. (*Journ. Cut. Dis., including Syph.*, vol. xxii, No. 266, November, 1904.)

UNDER this name the author records four cases in which single, pea-sized, bright-red growths were observed respectively on the ring finger, centre of palm, little finger, and tip of little finger. Three of the cases were women. One of the growths was demonstrated microscopically to be a granulation-tissue tumour, partly covered with a thin layer of polygonal epithelium and here and there some cylindrical basal cells, and partly denuded of epithelium and here and there slightly necrotic. Besides the connective-tissue cells there were small collections of lymphocytes about some vessels, a very few mast-cells, and on the periphery of the growth a moderate number of polynuclear leucocytes. The blood-vessels were so numerous and large as almost to suggest an angioma. A moderate number of yellow staphylococci were found in the superficial parts.

T. C. F.

(In the *Gaz. des Hôpît.*, August 4th, 1904, p. 865, is an article on the same subject by Paul Piolet, and the illustrations are reproduced in the December number of the *Medical Review*. It is stated that Legroux collected 52 cases, distributed as follows: 39 cases on the hands, 6 on the lower lip, 2 on the feet, 2 on the eyelids and eyebrows, and 1 each on the forearm, shoulder, and cheek.)

T. C. F.

REPORT OF A CASE OF BLASTOMYCOSIS. H. H. KOCHLER and G. C. HALL. (*Journ. Cut. Dis., including Syph.*, December, 1904.)

THE authors report a case in a coloured man, aged 39 years, a farm and railroad section-hand in Kentucky. The disease began as a "boil" at the angle of the jaw two years previously, and was soon followed by a similar lesion on the upper inner part of the right thigh. When seen by the authors there was a large, sharply-defined, moist, warty growth, mottled grey and red, extending from under the left ear to the median line, and exuding pus on pressure. Some related lymph-glands were enlarged and hard. A similar patch existed on the right thigh, and a third in the groin, with suppurating glands. The man otherwise appeared to be healthy, and no clue to tuberculosis or syphilis was obtained. The patches were excised and potassium iodide given internally.

The causal organism could not be found in the pus, but after about five days small, slowly-growing, whitish colonies grew on Loeffler's blood-serum and on an agar tube, composed of characteristic oval bodies (which are figured), some in process of budding, and a few elongated branching bodies simulating mycelia.

Sections of the skin displayed massive epithelial hypertrophy, containing numerous small abscesses. The organisms were found in these abscesses, and singly and in strings or bunches between the epithelial cells. Dr. Ormsby reported the skin-section to be typical.

T. C. F.

ON THE RELATION OF CERTAIN DERMATOSES TO EACH OTHER AND TO CHANGES IN VASCULAR EQUILIBRIUM.

J. N. HYDE and ERNEST L. McEWEN. (*Journ. Cut. Dis., including Syph.*, December, 1904.)

In this communication, which is preliminary to others, the authors attempt to study certain dermatoses of the hands and feet in their relation to each other and to a uniformly associated condition—that of vascular instability. The cutaneous phenomena displayed in the hands and feet, which are regarded as thus linked in a pathological chain, are as follows: Hyperidrosis localis, dysidrosis, hydroa, pompholyx, Cheiro-pompholyx, Keratoderma erythematosa symmetrica (Besnier), Keratoderma palmaris et plantaris, Keratosis palmaris et plantaris, Erythema keratodes, symmetrical tylosis of the palms and soles, Hyperkeratosis subungualis, Subungual keratoma, onychauxis, onychogryphosis, "chronic inflammatory diseases of many finger-nails," and Dystrophia unguium. The authors are careful to say that it would be an error to conclude that each of the morbid conditions represented in the list is solely due to vascular changes of the types here considered. A case representative of each step in the sequence of these phenomena is noted. Starting from a persistent retardation of the circulation with coldness commonly met with in the cachectic, tuberculous, and asthenic, a convalent hyperidrosis is next mentioned. Then follows the dysidrosis (or Pompholyx) of English authors, and the authors point out the wider signification given to this term by French writers. Further, the vulnerability of the moist hand and foot to the accidents of pressure and friction is responsible for a series of dermatoses illustrated by three fairly well defined grades of hyperæmia, inflammation (eczema), and ulceration. With the persistence of these morbid conditions, the integument invariably attains the keratoma stage. Two

grades of well-defined change in the nails, associated with sweating and circulatory disturbance, may be recognised, in which there is no accumulation of ill-formed corneous substance in the subungual space, and where there is antero-posterior curvature towards the point of the digit.

The authors conclude their paper by a further consideration (1) of the conditions under which vascular instability is established and lymph flow increased, and (2) of two essential pathological processes, viz., hyperidrosis and parakeratosis.

T. C. F.

LICHEN PLANUS VERRUCOSUS. A. RAVOGLI. (*Journ. Cut. Dis., including Syph.*, December, 1904.)

THE author discusses four cases of *L. planus verrucosus*, or *L. hypertrophicus*, or *L. ruber cornée*, in three men and one woman, all between 40 and 60 years, who had suffered attacks of *L. planus* for years, and exhibited lesions on the buccal mucous membrane. This "anomaly of the lesions of lichen" commenced by papules somewhat larger than in other parts of the body. In all there was a certain law or tendency to group in stripes or bands. The author notes a disposition for the lesions to be distributed along the internal side of the internal line of Voigt. He favours the idea of an autotoxic agent manufactured by any cause affecting the nervous system, and inducing changes in the general nutrition, e. g. gout. In consequence of vascular alteration, an exudation takes place in the corium, which causes an abnormal nutrition of the rete, with marked hyperkeratinisation. When the infiltration is absorbed, the connective tissues are left hard, atrophic, and cicatricial. In two cases the author effected a cure by local applications of formalin in full strength, in one by X-rays, in one by 10 per cent. solution of chrysarobin in traumaticin.

T. C. F.

EPITHELIOMATOSIS, WITH PIGMENTATION (SEAMAN'S SKIN OF UNNA). DALOUS and CONSTANTIN. (*Ann. de Derm. et de Syph.*, November, 1904, p. 961.)

THIS was a case in a joiner, aged 60 years. The father was definitely alcoholic, and died at the age of 57; it is recorded that he had an ulceration on his nose about the size of a sixpence, which had lasted for a year before his death. The mother died, aged 78 years, of an intestinal or uterine new growth. A maternal uncle, who died at the age of 72, had pigmented patches on his face dating from childhood. In 1895 the patient first took note of the lesion for which he came under the notice of the authors later. This was an irregularly circinate patch on his chest about 5 centimetres in diameter, covered with fatty, greyish, thick scales, leaving on their removal a red exuding surface. Similar lesions were again noted in 1899, and he was then seen for the first time by Audry. One of these patches, situated on the thigh, was then excised, and the patient was not seen again until 1904, when the present record was taken. The diseased appearances then present are grouped under the following four heads: (1) Pigmented patches, very widely distributed, circinate, from 1 to 6 millimetres in diameter, of a chamois to a milky-coffee tint, and even to a deep brown. (2) Pigmented patches with scales. On the palms these pigmented patches had warty growths on them.

(3) Depigmented patches, white, with smooth shiny surface, in the near neighbourhood of the pigmented areas, or co-terminous with them. (4) Pigmented patches, with crusts and tumours. Of these latter the largest was on the chest, occupying the greater part of this, and with a deeply ulcerated central portion. Near this tumour were several pigmented patches, and also on the back, but here there were numerous crusted patches as well. Upon the scalp and face were several pigmented patches, some with crusts, with a small tumour, the size of a sixpence, covered with a scab, upon the right temple. There were numerous pigment-patches on the neck. Upon the lower limbs similar maculae were very thickly distributed, some of them with scales, some without. On the upper limbs the maculae were less numerous, but on the right arm there was a red granulating patch 8 centimetres wide, with another smaller and similar in character near it. Upon the penis there were a few pigmented patches, but none on the scrotum, perineum, or buttocks. All four types of lesion described above were examined histologically, and are here reported in detail. These may be summed up briefly in the following points. The connective tissue is but little affected, except that the elastic fibres have disappeared to a great extent in the papillary layer, and that there are numerous pigment-cells in the superficial layers. The epithelium is chiefly affected, as follows: The germinal layer consists of cubical cells, with much pigment and not particularly numerous karyokineses. Of the rest of the site two zones may be distinguished, of which the superficial is especially altered, with vacuolation, numerous karyokineses, budding nuclei, irregularly fibrillated protoplasm, cell-nests; the process of keratinisation is completely disordered; the granules of keratohyalin are irregularly distributed, not in a zonal manner, with hyperkeratosis and parakeratosis, and elimination of pigment in the dehiscent layers of the stratum corneum. This pigment is not iron-containing. In this deeper layer the cells are irregular in size and shape; the prickles are not lost; the perinuclear cavity is exaggerated, with numerous pigment-cells between the rete-cells proper. The whole gives a picture of a fungating epithelioma of the Malpighian body remarkable for the number of mitoses, with no infiltration of the connective tissue. The analogies of this type of disease with other malignant dermatoses, such as Xeroderma pigmentosum and Paget's disease, are fully discussed. From Xeroderma pigmentosum of the classical type of Kaposi the histology serves best to differentiate this form—in which the changes are mainly epithelial, while in the other the connective tissue is largely and early implicated. Much confusion has, however, been caused by some writers describing this type of Unna as a form of late Xeroderma pigmentosum, forgetful of the different histology of these two affections. The histology of Paget's disease bears a much closer resemblance to the epitheliomatosis here described, but there are important differences, and the clinical picture is not similar.

For a bibliography the authors refer the reader to that contained in Lowenbach's article on this subject in Mracek's *Handbook*; they have been unable to add to this. Six microphotographs illustrate the histology and clinical appearance of the case.

E. G. L.

AUTOPSY OF A CASE OF ADENOMA SEBACEUM OF BALZER.

PELAGATTI. (*Ann. de Derm. et de Syph.*, November, 1904, p. 983.)

THIS was a typical case of Adenoma sebaceum of the pale variety in a young

man who had the collateral symptom of mental deficiency well marked. He died of pulmonary tuberculosis, aged 24 years. At the autopsy, besides tubercular changes in the lungs and intestines, certain yellow tumours were found upon the convolutions of the brain, and in its substance, upon the heart muscle, and upon the kidneys under the capsule. These lesions are those recognised as belonging to a rare disease of the nervous system known as Sclerosis tuberosa, accompanied by mental defects, and, it is contended by the writer, accompanied also by these skin changes, in which mental associations have for long been recognised as usually present.

The histological examination of the lesions of the skin showed the sebaceous hypertrophy commonly observed in such cases. But the glands, though hypertrophied, are normal in function, and it is probable that these cases of so-called Adenoma sebaceum are not examples of true adenoma, but rather of congenital deformities, analogous to nævi, and the term "sebaceous nævi" would probably express their character more correctly.

E. G. L.

PAGET'S DISEASE OF THE BONES [OSTEITIS DEFORMANS] AND INHERITED SYPHILIS. ETIENNE. (*Ann. de Derm. et de Syph.*, November, 1904, p. 990.)

LANNELONGUE, struck with the correspondence in many particulars of the changes of the bones in cases of hereditary syphilis with those in Osteitis deformans of Paget, hazarded the hypothesis that these two diseases are the same morbid entity. Fournier would admit the close analogies between them, but does not consider the case for their identity to be proved. Etienne here reports a case, occurring in a child, aged 6 years, in whom symptoms of hereditary syphilis coincided with changes in the bones typical of osteitis deformans. Several analogous observations, by Makins, Werther, Joachimsthal, Mills Jones, and others, are quoted in support of the view enunciated by Lannelongue.

E. G. L.

THE CEREBRO-SPINAL FLUID OF SYPHILITICS IN THE TERTIARY PERIOD. RAVAUT. (*Ann. de Derm. et de Syph.*, December, 1904, p. 1057.)

THE author has continued his researches, of which those relating to the cytology of secondary syphilis were published in this Journal in July last, to the tertiary period. He found on a general conclusion that all lesions of the central nervous system which are syphilitic in origin have accompanying changes at least in their earlier stages, in cytological features of the cerebro-spinal fluid. It further seems probable that this means of diagnosis will be available in advance of even the earliest clinical symptoms of nervous disease due to syphilis. The present research is directed to the study of the cerebro-spinal fluid in tertiary syphilis, attended by (1) lesions on the skin and mucous membranes. In fourteen such cases there was no abnormal change in the cerebro-spinal fluid. This result may be said to be the rule in cases where no affection of the nervous system has taken place; but there are some exceptions to it, and cases with gummata of the hard palate and tonsil seem especially often to infringe this rule. (2) Various manifestations, not nervous, but not confined to the skin; here this reaction is irregularly obtained; it was, for example, conspicuous in a case of syphilitic orchitis. (3) Ocular symptoms, syphilis involving the eye or optic

nerve. Here no general rule can be deduced, but most of the cases showed definite cerebro-spinal fluid changes, especially in early stages of the ocular disease. (4) Nervous symptoms not of such a degree that the clinical diagnosis is settled, but in which subjective and obscure objective symptoms are present. In the case of subjective manifestations, of which the principal is headache, the cytological reactions are for the most part negative. But it is otherwise with the objective manifestations. Of these, the most interesting is the Argyll-Robertson sign of the pupil, which, with the exception of one recorded case, has been invariably associated, in the experience of several observers, with cytological changes, so that Babinski regards the Argyll-Robertson pupil as characteristic of syphilitic disease of the nervous centres. It is probable that the observation of the cerebro-spinal fluid will give indications of the disease considerably in advance of the appearance of the Argyll-Robertson sign. The tendon-reflexes are less consistently associated with cerebro-spinal cytological changes, and no definite conclusion in this matter is as yet possible. (5) In old syphilis, with no symptoms, the cerebro-spinal changes are usually not present; in sixty such cases the reactions were negative. The paper concludes with the author's conviction that the presence of the cerebro-spinal cytological changes should be regarded as being of equal proof of the presence of syphilis as the lesions on the skin or in the viscera.

E. G. L.

SYPHILIS BY CONCEPTION, WITH LATE MANIFESTATIONS.

PERRIN. (*Ann. de Derm. et de Syph.*, December, 1904, p. 1977.)

THIS paper should cause a considerable shock to our English optimism in giving permission to marry to syphilitics who have had no manifestations of the disease for two years. For in these thirty-two cases in not a single instance was the husband's syphilis active, and no case in which the disease had not been apparently quiescent for at least three years is recorded. Yet the wife showed typical syphilis sometimes many years after the marriage, and in two cases women gave birth to syphilitic children by a second husband, who was apparently himself healthy, they having acquired syphilis from the first husband before the second marriage, but having shown no signs of the disease themselves. The fact of the syphilitic symptoms being delayed, and therefore untreated in the early stages, may account for this severity of the late symptoms, which comprise such grave manifestations as tabes, optic neuritis, choroiditis, and cerebral syphilis. It is remarkable that next to skin lesions in frequency are found affections of the nervous system. It is not without reason that the author quotes with approval Besnier's dictum that "every woman who has conceived by a syphilitic husband is, or may be syphilitic."

E. G. L.

NAIL CHANGES FOLLOWING SCARLET FEVER AND MEASLES.

E. FEER. (*Münch. med. Wochenschr.*, October 4th, 1904, p. 1783.)

NOT much attention has been paid to the condition of the nails in acute exanthemata. Some observers record a shedding of the nails after scarlet fever; but the author had not seen such an occurrence once in 300 cases. The purport of this communication is to show that there is a nail symptom of very frequent occurrence. This consists of a transverse furrow or, in some instances, a ridge,

It becomes apparent from four to five weeks from the commencement, travels along the nail, and disappears in about six months. The change is most obvious on the thumb nails. The thicker and more strongly developed the nails the more conspicuous the change. In children and people with thin nails it is inconspicuous. The lines seem to correspond to the intensity of the eruption. They appear to possess a certain value, seeing that the author in two cases of chronic rheumatism was enabled by their presence to discover the exciting cause. He suggests that in cases of nephritis their presence might prove very useful.

Similar lines are met with after measles. They are, however, less frequently present and less conspicuous.

Readers of this Journal acquainted with the work done by Mr. Hutchinson will not be inclined to attach the same importance to these lines as is done by the author.

W. B. W.

THE BACTERIOLOGY OF NOMA. A. HOFMANN and E. CÜSTER.
(*Münch. med. Wochenschr.*, October 25th, 1904, p. 1907.)

THE authors give the results of a bacteriological examination of a case of noma, whose histological details have already been published. As was to be expected, they found a great number of organisms in the necrotic portion of the ulcer; but in the marginal or freshly invaded tissues the sections only showed two forms: (1) A spirillum, very infrequent and hard to stain, and (2) a bacillus, growing in great abundance.

The spirillum did not appear in any of their cultures; but, by excising a minute piece of tissue, which was placed in gelatine, they obtained a pure culture of a spore-bearing bacillus which they believe to be identical with the one seen in the sections.

Its biological features are described in full. The bacillus produced no effect on any of the animals used to experiment upon, nor did it appear to form any toxin.

Seeing the close resemblance, histological and bacteriological, between noma and Angina Vincenti, it was curious to find that their bacillus differed essentially from the *Bacillus hastilis* which is regularly found in the latter affection, and sometimes in the former, in association with a spirillum.

Pérthes noted in a case of noma a mycelium with fine interlacing fibrils and spirillum-like ends, which he believed to have a pathogenic relationship. With certain differences, their results corresponded, and they suggest the possibility that, with similar methods, they might coincide completely.

W. B. W.

INFLAMMATION OF THE SKIN CAUSED BY THE PRIMULA AND OTHER PLANTS. E. HOFFMANN. (*Münch. med. Wochenschr.*, November 1st, 1904, p. 1966.)

A LADY developed regularly every year on her birthday a distressing "nervous eczema." It was subsequently found that she received a *Primula obconica* plant each year as a present.

The wife of a gardener developed an acute inflammation of the face, hands,

and arms, accompanied by fever. It appeared that she had been employed for two days, six hours a day, in cutting chrysanthemum (*C. indicum*) blooms. The year before she had developed a similar attack after doing the same work. The author had notes of two cases in which a vesicular inflammation of the hands and arms followed close contact with the leaves or bulb of the *Scilla maritima*.

Fresh squill root is used in Greece as a counter-irritant and vesicant.

Another case is mentioned in which an acute erythema of the face and hands appeared to follow immediately after contact with the crushed leaves of the arbor vitae tree (*Thuja occidentalis*.)

W. B. W.

CONGENITAL ONYCHOGRYPHOSIS. C. MÜLLER. (*Münch. med. Wochenschr.*, December 6th, 1904, p. 2180.)

MOST of these cases are associated with a congenital skin affection, particularly ichthyosis. The author now describes a case of a 14-year-old girl in whom the deformity of the nails was met with in association with congenital hypertrichosis, and also with a psoriasis of some years' standing.

W. B. W.

A CASE OF PECULIAR SWEAT SECRETION. N. PLATTER. (*Münch. med. Wochenschr.*, December 13th, 1904, p. 2230.)

THE patient, a woman in the climacteric period, had suffered for 15 years from severe migraine, for the relief of which she was in the habit of taking large and increasing doses of migranin. For the last three years she had been inconvenienced by an unpleasant secretion of brown sweat in the armpits. When the medicine was discontinued the sweating ceased, only to return again when the use of migranin was resumed. The author seems inclined to refer the phenomenon to the antipyrin contained in the migranin powder.

W. B. W.

PATHOLOGY OF PSORIASIS. A. CAMPA. (*Clin. Dermosif.*, January, 1905. Two plates.)

THE methods of examination were the following: Scrapings of the epidermis, after removal of the superficial scales, were placed consecutively in 1 to 1000 formaline and distilled water, then teased and placed in salicylic albumen, then in absolute alcohol for twenty minutes, after which they were stained with boricated methyl blue, washed with plain water, cleared with oil of bergamot, and mounted in Canada balsam.

Sections were similarly treated. Scales were also treated for a day or two with ether-alcohol, then with dilute alcohol, distilled water, and stained. The best stain was Giemsa's (*Centr. f. Bakteriologie und Parasiten*, Bd. xxi). Round, but more commonly oval, bodies, measuring $\frac{1}{2}$ to 1 micromillimetre, were seen in and on the epithelial cells. Their protoplasm was finely granular, less coloured at the periphery. The bodies, which are sometimes double, contain one or two nuclei. They are best seen in the deeper layers of the epidermis, and are not found in warts, corns, or eczema. They are compared to Donovan-Leishman bodies.

T. P. B.

ALTERATIONS IN BONE MARROW IN PEMPHIGUS. M. PELLAGATTI. (*Giorn. Ital. d. Mal. Ven. e della Pelle*, fasc. i, 1905. With plate.)

THE patient was a man, aged 60 years, who had been ill for one month, confined to bed for a week, and in hospital one day. His illness began suddenly, with erosion of the buccal mucous membrane and blisters on the face and scalp. The whole surface of the skin was soon affected. There was no heat or itching accompanying the formation of the blisters, but the raw surface left by their bursting was painful. The hairs of the scalp, eyebrows, and beard were matted with a sanious discharge. There was crusting around the nose and lips, and the eyes were closed by crusts formed on the eyelids. There were bullæ of various sizes, with turbid, and in some cases sanious, contents on the cheeks, forehead, neck, chest, and anterior surface of the trunk, on the palms and soles. Fairly regular, black crusts, exuding a sanious, extremely fœtid fluid, and surrounded by a red margin, were present. There were large, raw, red, moist, and very painful areas, with raised, red, and very moist borders, upon the back, loins, and internal surface of the thighs.

The blood-count showed 2,300,000 red corpuscles, 12,500 white; lymphocytes, 2 per cent.; large mononuclear, 36 per cent.; polynuclear, 61 per cent.; eosinophile, 1 per cent. The patient was conscious until an hour before death. The temperature varied from 37.5° C. to 38° C. (99.5° F. to 100.4° F.). The spinal cord, heart, pancreas, suprarenal capsules, and lymphatic glands were normal. The brain, spleen, and stomach were slightly congested. There were punctiform hæmorrhages on the visceral pleura and slight congestion in the lungs. The renal pyramids were slightly congested, the cortex swollen and granular. The medulla of the femur was abnormally hard and reddish-grey. The lesions observed were less marked than would be expected in a fatal disease, but were similar to those found at Parma in cases of pemphigus, which usually come from one locality.

The white cells from the interior of the femur showed 75 per cent. large mononuclear cells, with a homogeneous protoplasm, and a nucleus poor in chromatin, without granules in the basophile groundwork; 12 per cent. of the cells were eosinophile; 7 per cent. small lymphocytes; the remaining 6 per cent. were mononuclear, either basophile or neutrophile. Altogether, the polynuclear cells, either acidophile or neutrophile, did not exceed 0.50 per cent. The changes were most marked at the periphery of the medulla and gradually diminished towards the centre, which was occupied by fat: thin trabeculae, here and there swollen, and containing amorphous material, divided up the fat. The capillaries were for the most part small and empty, but here and there were dilatations full of blood, with a few myelocytes in the surrounding tissue. Stained specimens showed less than 1 per cent. mononuclear cells with iodophile granules, and also that the various cells were distributed in groups containing their own kind only.

T. P. B.

SCABIES OF ANIMAL ORIGIN. P. L. BOSELLINI. (*Giorn. Ital. d. Mal. Ven. e della Pelle*, fasc. i, 1905.)

A MAN, aged 55 years, and a boy, aged 14 years, had the care of a donkey. It suffered from severe pruritus, with bald patches covered with scales and crusts, and it quickly succumbed to marasmus. The man's arms were first affected, and

later the whole body. Nothing abnormal was detected on his hands. The eruption, which was most marked on the trunk, was papulo-vesicular in character and situated on a red base, with patches of urticaria interspersed here and there. The eruption was chiefly situated around the orifices of the sweat and pilosebaceous glands. The boy had itching of the limbs, intensified on exposure to the air. His forearms and legs were most affected, especially on the extensor surfaces, which exhibited marks of scratching and wheals, with an irregularly distributed papulo-vesicular rash. His hands, also, were unaffected.

On examination no acari or burrows were found on the patients. Treatment with glycerine of starch cured the man in three weeks and the boy in one.

A mule was attacked with prurigo, with desquamation and bald areas, covered with crusts. It was cured by its owner, who had suffered from a rash for three weeks when he came under treatment.

The rash, commencing on the hands and forearms, extended over the limbs and trunk. It was characterised by small papules, with excoriations and scattered hæmorrhagic crusts. The irritation was most marked when the skin was washed or exposed to the air. There was no evidence of burrows or acari.

A man, aged 39 years, had a sow suffering from a pruriginous rash, with scattered and squamous crusts, chiefly affecting the ears.

Forty days before the patient was seen he had scraped the sow's skin, and epidermic scales had fallen on his bare arms and feet. These parts became irritable, and were covered with wheals and papulo-vesicles scattered over the surface. Subsequently the whole body was affected, especially the chest and thighs, but the back and shoulders for a long time were unaffected.

On examination marked redness of the limbs and trunk, with evidences of urticaria, small papules, and vesicles, containing clear fluid, were seen. No burrows or parasites were discovered. Under treatment the formation of new papules ceased, but the urticarial condition persisted for a long time, especially on exposure to the air. A punctated pigmentation was long visible on the trunk. His wife, who slept with him, was unaffected. A fresh scraping from the sow was applied to a lad with *Tinea tonsurans*, and in two hours' time gave rise to urticaria on the lower limbs, arms, and trunk. This disappeared next day only to return at night, but ceased in ten days. No burrows or parasites were seen. A second application of scrapings preserved in an incubator caused urticaria of shorter duration and less intensity.

T. P. B.

OPTIC NEURITIS, IMMINENT BLINDNESS. CURE BY CALOMEL INJECTIONS. JULLIEN. (*Journ. des Mal. Cut. et Syph.*, July, 1904. p. 489.)

The patient was a medical man. He was suffering from optic neuritis of somewhat unusual character, but which afterwards proved to be syphilitic. One eye had been removed on the supposition that the affection was sarcomatous, anti-syphilitic treatment having failed. The sight was rapidly failing in the remaining eye in spite of treatment by soluble injections and by insoluble injections of salicylate of Hg. Treatment by injections of calomel was then commenced. .05 gm. was injected at intervals for two months, until twenty-nine injections had been given (1.45 grms. of calomel in all.) By this treatment vision was completely restored, so that the patient could again follow his profession.

H. G. A.

QUARTERLY SURVEY OF DERMATOLOGICAL LITERATURE.

HYPERÆMIAS AND INFLAMMATIONS.

- Acrodermatitis Chronica Atrophicans.** C. HERXHEIMER. (*Journ. of Cut. Dis.*, June, 1905, p. 241.)
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- Acne Vulgaris** and its Treatment. W. K. WILLS. (*Bristol Med.-Chir. Journ.*, June, 1905, p. 113.)
- Angio-Neurotic Œdema:** Report of a Case operated upon during an Abdominal Crisis. HARRINGTON. (*Boston Med. and Surg. Journ.*, March 30th, 1905.)
- Burn,** Extensive, of the Third Degree: Report of a Case of. A. N. FAUNTLEROY. (*Amer. Journ. of the Med. Sci.*, June, 1905, p. 985.)
- Burns,** Severe, On the Pathology and Treatment of. ST. WEIDENFELD and v. ZUMBUSCH. (*Archiv f. Derm. u. Syph.*, July, 1905, p. 77.)
- Creeping Eruption:** Report of a Case. J. B. SHELMIRE. (*Journ. of Cut. Dis.*, June, 1905, p. 257.)
- Chickenpox,** The Diagnosis of. SOMERSET. (*New York Med. Journ.*, May 27th, 1905, p. 1063.)
- Erythema and Urticaria,** with a Condition resembling Angio-Neurotic Œdema. Caused only by Exposure to the Sun's Rays. WARD. (*New York Med. Journ.*, April 15th, 1905, p. 742.)
- Erythema Exsudativum Multiforme and Appendicitis.** CHENOWETH. (*Fortschritte der Medizin*, April 20th, 1905.)
- Erythema Syphiloide Posterosivum** in Adults. DALOUS. (*Monats. f. prakt. Derm.*, June 15th, 1905, p. 633.)
- Erythema Induratum (Bazin).** FR. HIRSCH. (*Archiv f. Derm. u. Syph.*, June, 1905, p. 181.)
- Erythema Exsudativum Multiforme, Angina, Pleuritis Exsudativa Dextra.** EPSTEIN. (*Wiener klinische Rundschau*, February 5th, p. 73.)
- Erythema Scarlatiniforme and Gonorrhœa** W. H. S. STALKARTT. (*Brit. Med. Journ.*, June 24th, 1905, p. 1380.)
- Erythema Induratum of Bazin,** On an Atypical Case of. M. TRUFFI. (*Giorn. Ital. d. Mal. Ven. e della Pelle*, 1905, Fasc. ii, p. 129.)
- Exudative Erythema,** Two cases of Unilateral Convulsions and Paralysis in young Subjects Associated with. T. K. MONRO. (*Brit. Med. Journ.*, May 27th, 1905, p. 1144.)
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- "Gangrene, Hysterical,"** On the Ætiology of the so-called Spontaneous, or Neurotic. S. RÓNA. (*Archiv f. Derm. u. Syph.*, June, 1905, p. 257.)
- Gonococcic Infection,** Metastatic, of the Skin. AUDRY. (*Ann. de Derm. et de Syph.*, June, 1905, p. 544.)
- Lichen Ruber Planus Diffusus,** The Pathology of. SPIETHOFF. (*Monats. f. prakt. Derm.*, May 15th, 1905, p. 544.)

- Lichen Ruber Planus**, Contribution on. S. BETTMANN. (*Archiv f. Derm. u. Syph.*, June, 1905, p. 379.)
- Lupus Erythematosus to Tuberculosis**, On the Relation of. OTTO KREN. (*Archiv f. Derm. u. Syph.*, June, 1905, p. 303.)
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- Psoriasis Diffusa**, A Case of. W. HIND. (*Lancet*, May 27th, 1905, p. 1420.)
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- Scleroderma**, Case of Circumscribed, Treatment with a Mesenteric Gland Preparation. C. SCHWERDT. (*Münch. med. Wochenschr.*, March 14th, 1905, p. 509.)
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- Ulceration of the Skin and Connective Tissue**, Widespread, A Case of. W. BERTRAM WATSON. (*Lancet*, June 3rd, 1905, p. 1487.)
- Urticaria Pigmentosa**, A Case of. D. MACMASTER. (*The Australasian Medical Gazette*, vol. xxiv, No. 6, June, 1905, p. 270.)
- Urticaria Xanthelasmaidea**. G. NOBL. (*Archiv f. Derm. u. Syph.*, June, 1905, p. 163.)
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- Actinomycosis**, Two Cases of. D. DOUGLAS-CRAWFORD. (*Lancet*, July 15th, 1905, p. 157.)
- Actinomycosis**, the Biology of the Micro-organism of. J. H. WRIGHT. (*Boston Journ. Med. Research*, May, 1905, vol. xiii, No. 4, p. 349, bibliography and plates.)
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- Anthrax**, Case of Cutaneous, treated without Excision with Selavo's Anti-Anthrax Serum: Recovery. WM. MITCHELL. (*Brit. Med. Journ.*, July 15th, 1905, p. 118.)

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- Atrophy**, Macular, of the Skin. E. H. SHIELDS. (*Lancet-Clinic*, February 4th, 1905.)
- Acanthosis Nigricans** following Cancer of the Breast. MENAHEM HODARA. (*Monats. f. prakt. Derm.*, June 15th, 1905, p. 629.)
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- Pseudo-xanthoma Elasticum**. C. GUTMANN. (*Archiv f. Derm. u. Syph.*, June, 1905, p. 315.)
- On Verruca Senilis and Epithelioma originating from it**. L. WAELSCH. (*Archiv f. Derm. u. Syph.*, July, 1905, p. 31.)

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- Keratosis Palmaris et Plantaris in Five Generations**. F. H. JACOB AND ADAM FULTON. (*Brit. Med. Journ.*, July 15th, 1905, p. 125.)
- Melanosis Lenticularis Progressiva** (Xeroderma pigmentosum). On the Histology of. v. BAUDLER. (*Archiv f. Derm. u. Syph.*, July, 1905, p. 9.)
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- Baldness**, The Causes and Treatment of. H. WALDO. (*Bristol Med.-Chir. Journ.*, June, 1905, p. 107.)

- Dermatitis Papillaris Capillitii** (Kaposi), the Anatomy of. Dr. JOSEF GURGMAN. (*Derm. Zeitschr.*, March, 1905, p. 139.)
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- Trichorrexia Nodosa**. M. L. HEIDINGSFELD. (*Journ. of Cut. Dis.*, June, 1905, p. 216.)

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- Epithelial Fibres in the Skin**, New and Simple Method of Demonstrating. PASINI. (*Monats. f. prakt. Derm.*, May 1st, 1905, p. 492.)
- Fæces**, Analysis in Dermatoses. OEFELE. (*Monats. f. prakt. Derm.*, June 1st, 1905, p. 595.)
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From MASSON AND CO., Paris, 1905. *Manuel Élémentaire de Dermatologie Topographique Régionale*. By R. SABOURAUD. Price 15 fr.

From H. K. LEWIS, London, 1905. *Diseases of the Skin*. By H. RADCLIFFE-CROCKER, M.D., F.R.C.P. Third edition, with 72 additional plates. Price 30s. net.



URTICARIA PIGMENTOSA NODULARIS.

CASE OF EDWARD W. (OBSERVATION 8).

TO ILLUSTRATE DR. GRAHAM LITTLE'S PAPER ON URTICARIA PIGMENTOSA.

THE BRITISH JOURNAL OF DERMATOLOGY.

OCTOBER, 1905.

A CONTRIBUTION TO THE STUDY OF URTICARIA PIGMENTOSA.

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MUCH has been written of late years on the subject of Urticaria pigmentosa, notably by German authors, the careful monographs of Reiss, Blumer, Bäumer, and Nobl, to which frequent reference will be made, being especially important studies of this disease. But, in spite of the attention concentrated recently upon it, the affection still remains entirely obscure, and it is therefore possible that a careful record of a series of cases which it has been my accidental good fortune to observe in my own practice may prove of interest. I propose to describe my own cases in detail first, and then to make some general remarks upon the disease founded upon the study of these cases and of the available literature on this subject. All the cases about to be described, with the exception of Cases 12 and 13, have been shown at the Dermatological Society of London, and in all these cases the clinical diagnosis of Urticaria pigmentosa was supported by the unanimous opinion of that Society. I wish to emphasize this point, as in certain cases recorded in the literature as examples of Urticaria pigmentosa the clinical diagnosis of that disease had not met with general acceptance.

OBSERVATION 1. (ST. MARY'S HOSPITAL.)

Alice B—, aged 2 years, of English parentage. The family consists of the parents and two children; the other child is not affected, and there is no skin-disease in the parents, and especially no history of urticaria.

Onset of the disease.—The child was born perfectly clear of erup-

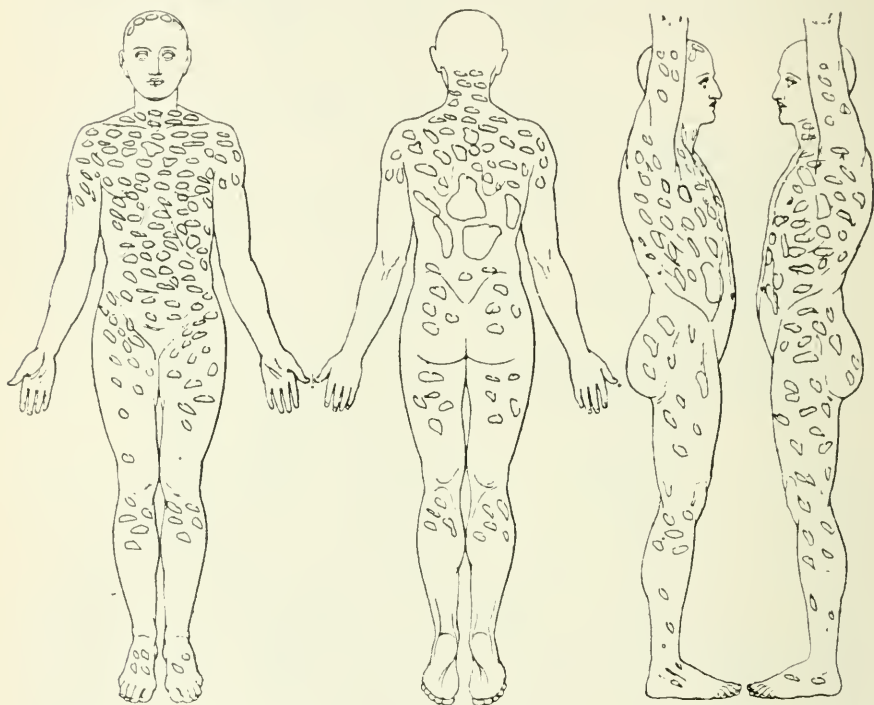


FIG. 1.

tion, and it was not until about the age of 6 or 7 weeks, immediately "after vaccination" (within one week), that the eruption was noted for the first time. The rash took about three weeks to develop; there was no itching, and no history of insect bites. She did not have intestinal disturbances of any kind preceding the appearance of the rash.

Character and distribution of the eruption (Fig. 1).—There is a very copious macular eruption, the lesions being perfectly flat throughout, so that with the eyes closed one cannot detect by touch alone the presence of the eruption. This is made up of macules, which are

not very sharply demarcated from the healthy skin, the colour fading almost imperceptibly into that of the normal skin; the macules are round and oblong, of various sizes, from that of a pea to that of a Brazil nut; in the oblong patches the long diameter is as a rule in the girdle-axis of the body. There is faint striation and an ill-defined lustrous sheen on the surface of the patches. There is occasional coalescence of several individual spots to form larger patches; on the back of the trunk there are patches the size of the palm of the hand which have been formed in this way. The colour is the same in all the lesions, and is of a very pale chamois-leather tint which is at times hardly to be distinguished from that of the normal skin. *Distribution*: This is particularly copious on the abdomen, back, and chest, and here the patches are largest; the sides of the body, from the axillæ to the thighs, are nearly entirely covered by patches running obliquely in the direction of the ribs. On the anterior surface of the thighs there are also several patches with the long diameter running obliquely from above downwards and forwards; there are a few very faint patches on the posterior surfaces of the thighs. There are a few patches along the flexor and extensor aspects of the legs down to the ankles, and in the dorsal surface of the feet; the soles remain free. There are a few faint patches on the shoulders and upper arms and on the flexor aspect of the forearms. The hands are perfectly free from patches. The face below the forehead is practically free; but there are typical lesions upon the temporal region and the forehead, over the greater part of the scalp, and upon the neck. There are no lesions in the mouth.

The eruption is not itchy, and there is only moderate factitious urticaria where the healthy skin is scratched. But the macules speedily become red and swollen when irritated in any way.

The glands are quite noticeably enlarged in the posterior and anterior triangles of the neck, and especially those along the margin of the sterno-mastoid. They are also enlarged in the axillæ and groins. The child enjoys good general health. Her weight is 1 st. 8½ lbs, height 2 ft. 8 ins.

She is a blonde, with light-coloured hair, and greyish-brown eyes.

HISTOLOGY.

Alice B— (Fig. 2). Specimen of skin taken from the back. The epidermis was rugose and thinned in places, corresponding to the accumulations of mast-

cells below. The stratum granulosum was absent. There was much intra-cellular and interstitial epithelial œdema; this was especially marked in this case. Pigment-cells were found in several layers of the rete, not confined to the basal layer. No wandering pigment-cells were seen in the corium in the sections examined. The pigment-granules were especially dark in colour, in places almost black, and the granular envelope was particularly rich.

Mast-cells were found in very large numbers, the arrangement being principally round the blood-vessels in the sub-papillary plexus and around the portions of the hair-shaft found in the corium. The cells were extraordinarily numerous, but in obvious rows and lines, not disseminated, as in the case of C. B— and E. W— (Nos. 4 and 8). The greatest mass of these cells was immediately below the epidermis; in the deeper parts of the corium they became scanty and were practically confined to the neighbourhood of the sweat-glands. The mast-cells were well formed, with normal nuclei and abundant granules.

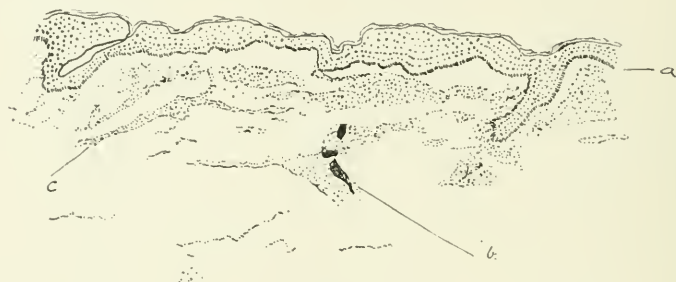


FIG. 2.—Stained with polychrome methylene blue + alum. Drawn with camera lucida ($\times 70$). *a*, Basal layer of epidermis, with pigment-cells; *b*, portions of hair-shaft, surrounded by mast-cells; *c*, enlarged blood-vessels, outlined by mast-cells. The infiltration of the corium, as figured, is composed of mast-cells.

The elastin was conspicuously dissociated in the position of the accumulation of mast-cells, and it was only in the deeper parts of the corium that elastin was found with normal arrangement. The collagen was similarly dissociated and thinned out. The blood-vessels were especially dilated and numerous. In sections stained so as to bring out only the mast-cells conspicuously the whole blood-vessel appeared as though constituted by these cells.

OBSERVATION 2. (ST. MARY'S HOSPITAL.)

Lilian C—, aged 3 years, of English parentage. There are two other children in the family, neither of whom are in any way affected. The mother was quite well during her pregnancy, and no drug was administered to her except iron. The child was apparently free at birth, and the eruption was noted only fourteen days after; but the mother had not seen the child stripped until at this period. There were only a few spots at first, and there have been fresh lesions from

time to time, especially during the past year. The child was "restless during the first few months after birth," but no special illness is recorded.

Character and distribution of lesions.—These are nearly uniform in appearance, varying from $\frac{1}{16}$ to $\frac{1}{4}$ of an inch in diameter, and usually oval or round. They are of a light-brown colour, with a faint tinge of yellow in some and a suffused pink in others. The lesions are very numerous, but all small. There is no grouping noticeable. *Distri-*

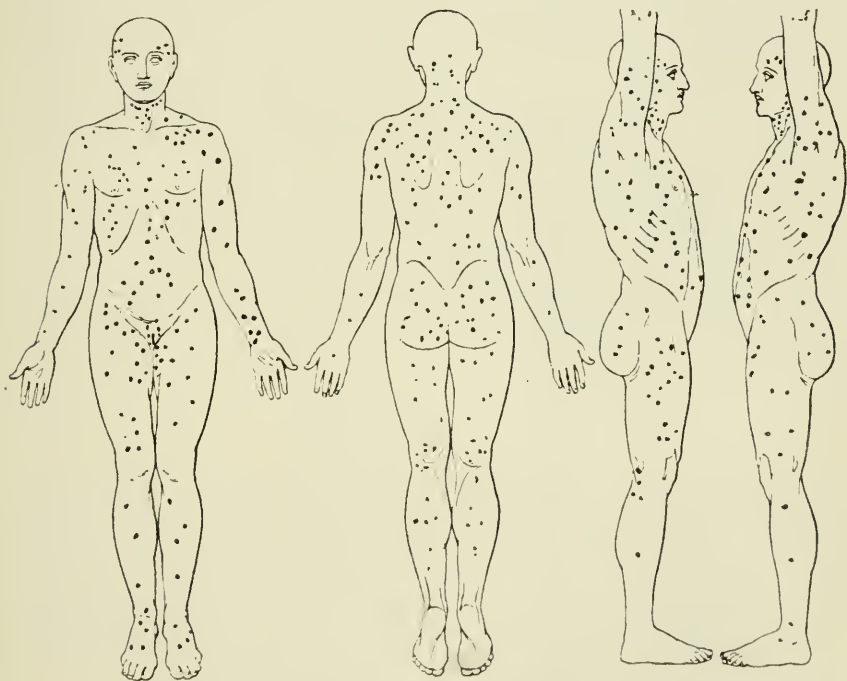


FIG. 3.

bution (Fig. 3): They are most numerous on the back, where they are very thickly distributed, leaving no free space larger than the size of a florin; they seem to run somewhat in the girdle-axis of the body here, as well as upon the chest and abdomen, where they are almost equally copious. They are also very thickly distributed over the inner and upper surface of the thighs, and on the pubes and labia majora, but the mucous membrane of the vulva is free. The lesions are fairly numerous on the front and back of the thighs, fewer below the knee, and again numerous on the dorsum of the feet, but not on the

soles. There are several macules upon the upper arms on both flexor and extensor surfaces; there are a few isolated spots on the forearm, more thickly on the flexor than extensor surface, and one lesion on the back of the left hand, but the palms remain free; they are numerous on the neck, and there are a few isolated stains on the cheeks and the temples, but the scalp remains clear. There are several small punctiform patches of a very light brownish-yellow colour on the mucous membrane of the cheeks, but not elsewhere on the buccal mucous membrane. The lesions on the skin are perfectly flat throughout; it is a strictly macular eruption; but when irritated in any way there is a turgid redness in the macule which obliterates its yellow colour. There is slight itching when the child is exposed, but it is in no way a prominent symptom and there is no intervening factitious urticaria; no wheal-formation beyond the limits of the macules.

The glands at the angles of the jaw, in the posterior triangles of the neck, in the axillæ and groins are all noticeably enlarged. The child is otherwise in remarkably good health, and is a particularly placid, good-tempered little person. She has pale yellow hair and blue eyes.

HISTOLOGY.

Lilian C— (Fig. 4). The specimen of skin was taken from the back. The arrangement of mast-cells in this case is somewhat unusual, the cells being more numerous in the deeper than in the superficial part of the corium, but nowhere so copiously massed together as in some of the other cases. There is therefore no marked rugosity of the surface, no eminences corresponding to masses of mast-cells, and no appreciable thinning of the epidermis. There is, however, the usual marked vacuolation of some of the epidermal cells (*altération cavitaire*) with diminution but not entire absence of the keratohyalin granules.

Pigment-cells.—These are especially well formed and abundant in granules, staining a deeper colour, nearly brown in parts, than usual; the cells are also distributed through several layers of the epidermis, and are fairly numerous in the corium near the basal layer; they look rather like mast-cells in that they are fusiform, with a nucleus surrounded by a rich nimbus of granules, but these stain, of course, quite differently from mast-cell granules.

Mast cells.—These are also particularly well-formed cells with well-marked nucleus and abundant granules. There is in this case none of the broken-up *débris* seen in some other cases. The arrangement of the cells, as has been noted above, is also somewhat peculiar; the interpapillary zone of the corium is nearly free from mast-cells. The greater part of the distribution is around the vessels in the deeper strata of the corium; here numerous vessels are richly outlined by mast-cells, and small groups of these are also found around the sweat-glands and

ducts and the hair-shafts. The superficial vessels seem hardly at all dilated, but the deeper ones obviously are.

Elastin and collagen.—The elastin is not so visibly altered in disposition as in many of the cases; the fibres are thin, and are present in normal quantity throughout the section. Nevertheless, considerable dissociation has taken place, and it is obvious in sections stained with Weigert alone that lacunæ exist larger than could be accounted for by the actual displacement by the mast-cells themselves. This is still more obvious in sections stained with Weigert's solution, counter-stained with saffranin. The least dissociation is in the superficial (interpapillary) zone of the corium; where elastic fibres pass up into the epidermis even beyond the limits of the basal layer; there is some fragmentation of the elastin, especially in the deeper corium. The collagen shows some of the reticular metamorphosis and thinning described by Unna, but less in this case than in some others here



FIG. 4.—Stained with polychrome methylene blue + alum. Drawn with camera lucida ($\times 70$). *a*, Basal layer of epidermis, with pigment-cells; *b*, dilated blood-vessels outlined by mast-cells; *c*, portion of hair-shaft with mast-cells near; *d*, small glands and ducts with mast-cells near. The infiltration of the corium figured above consists of mast-cells.

recorded. It is interesting to note that the pigment, which is especially copious and dark in colour in this case, corresponds with clinical lesions which were somewhat conspicuously light in tint.

OBSERVATION 3. (HOSPITAL FOR SICK CHILDREN, GREAT ORMOND STREET.)

Alfred P—, aged 3 years. The parents are Russian Jews. This patient was admitted to the Hospital for Sick Children, Great Ormond Street, under the care of Mr. C. S. Ballance (to whom I am deeply indebted for his permission to report the case and for his

kindness in procuring me a section of the skin), and was there being treated for multiple abscesses connected with bone disease from which he began to suffer in March, 1905. By the courtesy of Mr. Ballance's house-surgeon, Mr. Duncan Fitzwilliam, I am informed that the bone disease was considered to be tuberculous.

There are four other children in the family ; all of them are free of the disease. The eruption first appeared at the age of 2 months ; the child was quite clear at birth. No fresh lesions have come out of late.

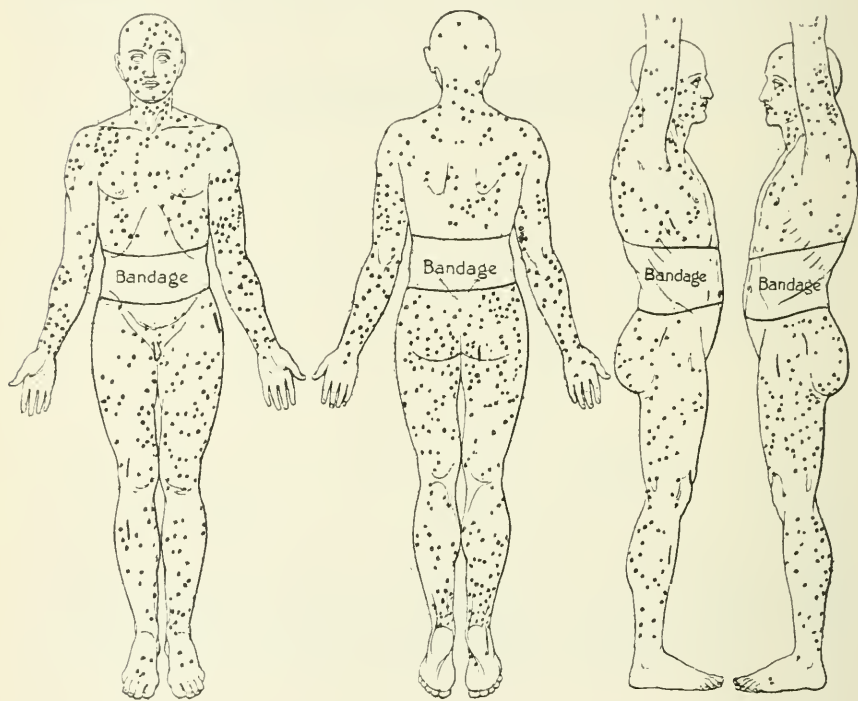


FIG. 5.

Character and distribution of the eruption (Fig. 5).—The lesions are strictly macular ; there is no infiltration or elevation of the patches ; these are of various shapes and sizes, of a light to dark brown colour, except when irritated, when they are a deep pink. They are extremely numerous, especially on the arms, legs, abdomen, and buttocks, and the forehead and face ; no portion of the body is free except the palms and left sole ; the right plantar surface has a few lesions. The scalp has only a few spots. The buccal mucous

membrane remains quite free. The glands in the neck, axillæ, and groins are all definitely enlarged. There is no marked itching.

HISTOLOGY.

Alfred P— (Fig. 6). Section of skin from abdomen. The epidermis is very rugose, but there is no noticeable thinning of it. The keratohyalin appears normal in quantity. There is some intra-cellular œdema (vacuolation of epidermal cells—*altération cavitaire*), especially in the lower layers of the rete.

Pigment-cells.—These are very numerous and rich in granules, which stain a vivid deep greenish-yellow colour with polychrome blue + alum. There are numerous pigmented cells in the corium (pars reticularis). It was possible in this case, owing to a concomitant surgical operation, to obtain a much larger section of the skin than in any other case; it is interesting to note that the pigmentation of the basal layer is persistent throughout the section, whereas the mast-cells are found only in restricted portions of the excised patch.

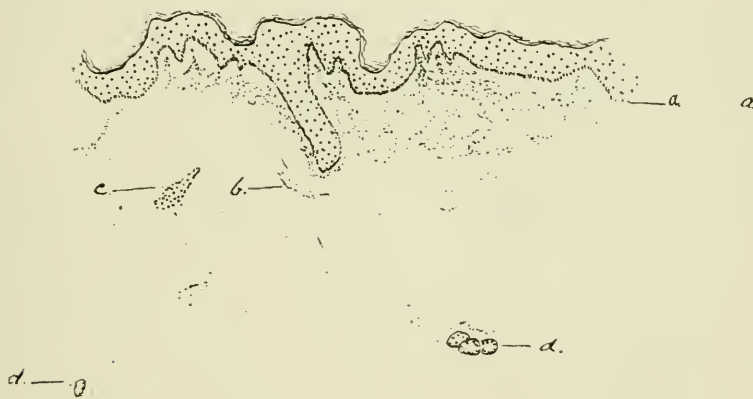


FIG. 6.—Stained with polychrome methylene blue + alum. Drawn with camera lucida ($\times 70$). *a*, Basal layer of epidermis, with pigment-cells; *b*, enlarged blood-vessel outlined by mast-cells; *c*, portion of hair-shaft with mast-cells near; *d*, sweat-glands with mast-cells near. The infiltration of the corium, figured above, consists of mast-cells.

Mast-cells.—The masses of mast-cells are found only in the interpapillary zone, especially around the papillary branches of the vessels. The infiltration is more scanty in this case than in any of the others here recorded, and contrasts with the richness of pigment-cells. The mast-cells are particularly well formed, with long fusiform envelopes of granules taking the stain excellently. There are a few isolated mast-cells scattered in the deeper zone of the corium, and some groups around the hair-shafts and sweat-glands and ducts.

Elastin and collagen.—The elastin is comparatively little disorganised, but lacunæ exist, in which the mast-cells lie. Occasionally thin elastin fibres penetrate the masses of mast-cells. Considerable fragmentation of the elastin is noted, especially in the pars reticularis. The collagen bundles are dissociated in places (rarefaction), but not very conspicuously.

The blood-vessels in the superficial (papillary) zone are obviously dilated.

OBSERVATION 4. (EAST LONDON HOSPITAL FOR CHILDREN, SHADWELL.)

Cecil B—, aged 12 months, of English parentage. There are five other children, all of whom are free of any skin-disease.

The child was prematurely delivered at eight months. The mother had an accident during her pregnancy and injured her fingers, and had a poisoned foot. She had no drugs during pregnancy. There

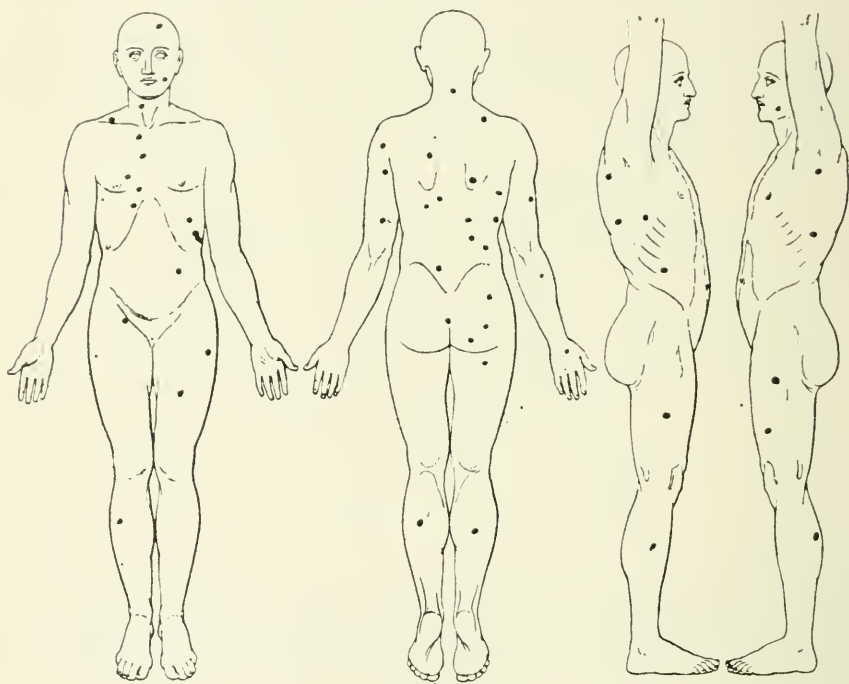


FIG. 7.

was no eruption on the child at birth; this first appeared two to three weeks after birth.

Character and distribution of lesions (Fig. 7).—These are deep brown, walnut-coloured nodules, raised about one eighth of an inch from the surrounding skin, and of various shapes—triangular, oblong, and oval—from a quarter to one eighth of an inch in diameter. They are smooth, shiny, tense swellings, with marked surface-striation. They are not very numerous, being about thirty in all, with the following distribution: one on the forehead; one on the left cheek; three small

papules arranged in a line on the right upper arm; one patch on the left upper arm; two on the left forearm; one on the front of the right thigh, near the groin; three on the upper left thigh; one on the middle of the posterior aspect of each thigh; one on the left calf and on the right calf; six patches on the scalp; several patches scattered over the back. The nodules swell and become red on being irritated, and there is well-marked factitious urticaria in the intervening healthy skin. There are no lesions in the mouth. The glands in the posterior triangles of the neck, in the axillæ, and in the groin are all enlarged. Itching is a somewhat severe symptom. The child is otherwise fairly well; there are no symptoms of diarrhœa or intestinal disturbances.

The weight is 1 st. 2 lb. 4 oz.

The hair is light yellow, the eyes blue.

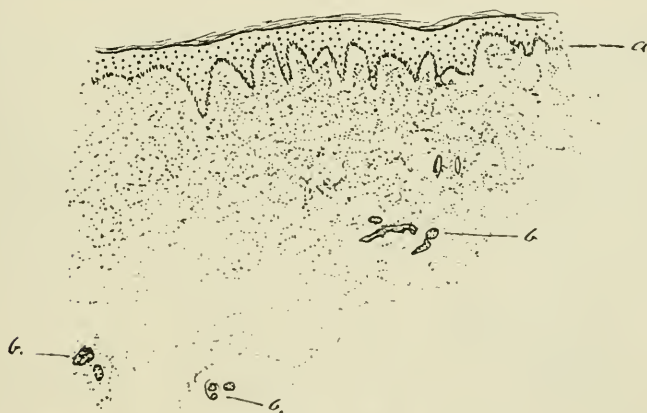


FIG. 8.—Section stained with polychrome methylene blue + alum. Drawn with camera lucida ($\times 70$). *a*, basal layer of epidermis with pigment-cells; *b*, sweat-glands, with mast-cells near. The infiltration of the corium figured above consists of mast-cells.

HISTOLOGY.

Cecil B— (Fig. 8). Section of skin taken from the back. The patch excised was a small nodule of a deep brown colour. The epidermis is distinctly flattened and somewhat thinned over the tumour, as if considerable tension from below had smoothed out the folds of the skin. Kerato-hyalin in the granular layer is abundantly present. There is very marked vacuolation of epidermal cells (*altération caritative*), but no interstitial œdema.

Pigment-cells.—The granules are scanty, the cells ill-formed, and the pigment light in colour; the cells do not occur outside of the basal layer of the epidermis.

Mast-cells occur throughout the thickness of the corium down to the hypo-

derm; they are extremely copious and massed together like a mosaic without any obvious arrangement around blood-vessels; the cells are largely broken up, much granular *débris* being deposited, and this *débris* stains in the manner characteristic of mast-cell-granules, so that the section has a general red tint. There are numerous individual well-formed mast-cells, with nuclei and somewhat scanty granular envelopes. The blood-vessels do not appear conspicuously enlarged or numerous.

The mast-cells cease to be thickly distributed below the level of the junction of the corium with the hypoderm, but there are small groups round the sweat-ducts deeper than the general infiltration.

Elastin.—Both the elastin and the collagen are very much thinned out in the tumour—the elastin is practically absent in the mass of the nodule where the mast-cells are thickest. In sections stained with Weigert's solution the staining is apparent only in the deepest layers of the corium, where it joins the hypoderm. Here the elastin fibres are felted together as if forced apart by the overlying mass of cells.

It is noteworthy that in this case, where the colour of the lesions was particularly dark, the pigment should be especially scanty and light in tint.

OBSERVATION 5. (EAST LONDON HOSPITAL FOR CHILDREN.)

Thomas M—, aged 9 years, of English parentage. There are five other children in the family; all of them remain free of eruption. The disease was first noticed fourteen days after birth, when the mother washed him, having recovered from the illness of her confinement. The earliest patches were on the neck and shoulder; during the ensuing six weeks fresh spots appeared, the eruption being complete at the end of that time.

There was no maternal illness, and no drugs were administered during pregnancy; the mother denies any possibility of bug-bites being a factor in producing the eruption.

Character and distribution of the eruption.—This consists of macules of a very pale brown tint, ill-defined for the most part and not sharply differentiated from the healthy skin. There is no prominence of the lesions when these are not irritated, but they speedily become turgid and red when scratched. They have not changed in any way since they first came out. They are oval and oblong for the most part and vary in size from a quarter to one inch, the larger patches being the paler. The distribution is as follows: There are two patches on the front of the neck, two just above the right nipple, one two inches below the xiphoid cartilage and about half an inch to the left of the middle line, another two inches below this latter spot, to the right of

the middle line; there are two spots in the mid-axillary line, about two inches below the axilla on the right side, one large faint brown patch over the last rib on the right side, one in the right groin, one or two small and very faint coloured in the middle of the left thigh, on the anterior and on the inner sides of the limb, one at the outer part of the spine of the scapula and one just below this (these two are the darkest in colour of all the patches), one very faint and large patch on the skin over the middle of the right biceps muscle, one just below the angle of the left jaw, and one behind and above the angle of the right jaw; there are two small raised buff-coloured patches on the mucous membrane of the mouth (on the side of the cheek.)

It will be seen, therefore, that the eruption in this case is scanty and faint-coloured, but apparently there has not been any retrogression of the disease, these features having distinguished the case throughout its history.

The glands in the neck, along the sternomastoid muscle, in the anterior and posterior triangles, in the axillæ on both sides, are all enlarged to a noticeable degree.

There is moderate factitious urticaria when the skin is scratched between the macules, and these latter become readily reddened and swollen upon being scratched. There is no itching, and the general health is excellent.



FIG. 9.—Stained with polychrome methylene blue + alum. Drawn with camera lucida ($\times 70$). *a*, basal layer of epidermis, with pigment cells; *b*, dilated blood-vessels, outlined by mast-cells. The infiltration of the corium figured above consists of mast-cells.

HISTOLOGY.

Thomas M— (Fig. 9). The specimen of the skin was taken from the back. The epidermis is thinned and thrown into many microscopic eminences, which are seen to correspond to massed accumulations of mast-cells immediately below the epidermis. There is considerable vacuolation of cells (intra-cellular oedema) in parts of the section, with loss of keratohyalin.

Pigment-cells.—These occur in several layers of the epidermis beyond the basal layer, and also free in the corium. The cells are rich in pigment-granules, which are of a dark colour, but not so dark as in the case of Lillian C—. The pigmentation is continued beyond the margins of the infiltration with mast-cells, but is, on the whole, more marked in proportion to the infiltration, being less where this is absent.

Mast-cells.—These are found in masses, in two positions, around the superficial vessels in the interpapillary zone of the corium, and again around the deeper vessels. There is very little dissemination of cells beyond these limits, except for a few cells grouped about the sweat-glands and hair-shaft in the hypoderm. The cells are well formed in the sparser collections, but are somewhat broken up and without distinct nuclei where the infiltration is thickest.

Elastin and collagen.—The elastin is much broken up and dissociated, and the collagen shows rarefaction to a notable degree. The blood-vessels are markedly dilated throughout the section.

OBSERVATION 6. (EAST LONDON HOSPITAL FOR CHILDREN.)

David R—, aged $3\frac{1}{2}$ years, of English parentage. He is one of several children, but is the only child who is affected. The eruption was first noted on the occasion of the first washing of the child, a few days after birth. It was then, and still remains, moderately itchy.

Character and distribution of the eruption (Fig. 10).—This was entirely macular, the skin being very extensively covered by stains of a buff-yellow to light brown colour. It was particularly copious about the neck and shoulders and on the back of the body. It was, though extensive in distribution, very irregularly and asymmetrically disposed, the left side of the body from the level of the hips being much less affected than the right similar portion of the person. The eruption did not go down the legs lower than the calf, but over this part was rather thickly grouped. There were a few patches of pigmentation upon the fronts of the arms and forearms, but not upon the backs of these. There were a few patches on the inner side of the arm in the axillary surfaces of these. The face, palms, and soles remained entirely free of eruption. The patches were of various shapes and size, in the latter respect from $\frac{1}{8}$ to $\frac{3}{4}$ of an inch in diameter; they were mostly oval or round. The patches, though perfectly flat, became readily turgid and flushed when irritated. Itching was not a prominent symptom and the child's general health was very good. He was kept under observation for about two years, and then was lost and could no longer be traced. No biopsy was

obtainable, and the condition of the glands and blood was not ascertained. He had been seen about two years previously by Dr. Radcliffe-Crocker, who had demonstrated the case as one of Urticaria pigmentosa at the Polyclinic; and it is possible the case may have been published by Dr. Radcliffe-Crocker, though I have not been able to ascertain this.

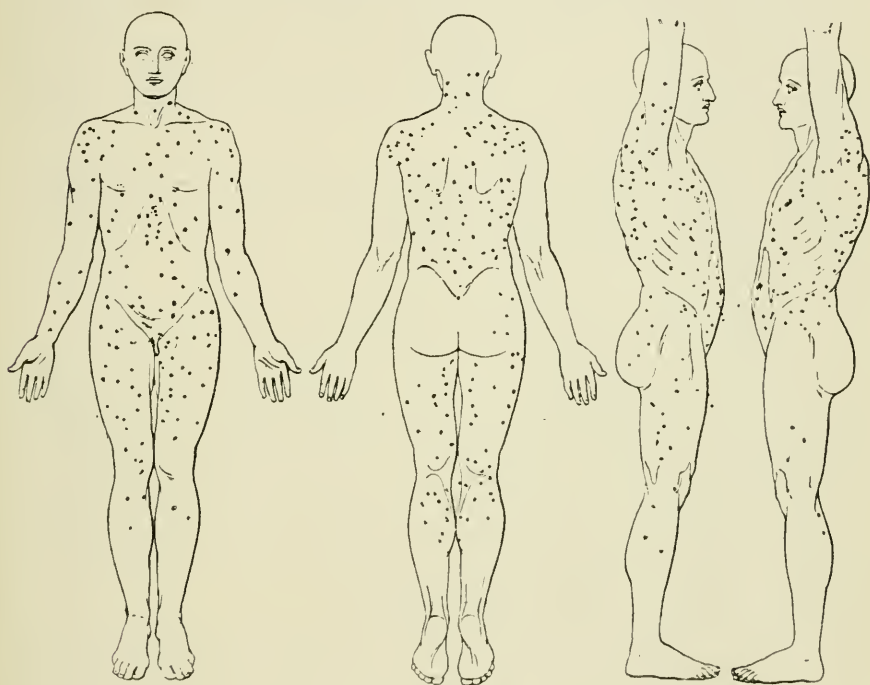


FIG. 10.

OBSERVATION 7. (EAST LONDON HOSPITAL FOR CHILDREN.)

Esther S—, aged 3 years, of English parentage. One of a family of two children; the other child remains free of the disease.

This case began apparently as an ordinary urticaria, at the age of 4 months; pigmentation began to be noted only at the age of 12 months. Other similar lesions have appeared since that time.

Character and distribution of the eruption.—The lesions are strictly macular, and are almost perfectly flat except when they are scratched, then they become swollen and reddened. The older lesions are a rather dark wash-leather colour, only just perceptible to the finger

when not aided by sight. There are about 40 to 50 such patches, scattered irregularly over the nape of the neck, the shoulders, the forearms, lower part of the abdomen, buttocks, and calves.

Factitious urticaria can be obtained. Several wheals, brought up by scratching the unpigmented skin, were watched and did not give rise to pigmented permanent stains. There are no scars.

The child was an exception to the general rule of a healthy constitutional condition being associated with this disease. She had pronounced rickets, with large pendulous abdomen and lordosis, and disordered ravenous appetite, and had been subject to night terrors since the age of 2 years.

The request for permission to perform a biopsy resulted in the loss of this patient before any examination of the blood could be made. The condition of the glands was not noted.

OBSERVATION 8. (EAST LONDON HOSPITAL FOR CHILDREN.)

Edward W—, of English parentage, aged 4 months when he first came under observation. There are two other children in the family, both unaffected. The eruption made its first appearance upon the head and face at birth; the doctor in attendance at the confinement considered these congenital marks to be *nævi*. But at the age of 1 month a fresh outbreak took place, and when the child was seen, at 4 months of age, he had numerous lesions.

Character and distribution of the lesions.—The eruption consists of dark brown nodules, varying in size from one eighth of an inch to an inch or more, and raised quite a quarter of an inch from the surface. The nodules are very firm and hard, like keloids, and have a glistening aspect that almost suggests the presence of fluid. Upon pricking with a needle the mass is, however, demonstrated to be a solid elevation. They are not itchy, but upon being scratched the brown colour is suffused with pink, and a pink halo surrounds the nodule at the base. In many of the nodules this halo is faintly visible, probably as the result of friction by the clothes, etc. This halo, the mother notes, becomes paler in cold weather and when the child is taken out into the air. The mother does not think any fresh lesions have appeared since the general outbreak which marked the attainment of the age of 1 month.

Distribution (Fig. 11).—The greater part of the eruption is on the back, which accordingly was selected for the water-colour representation, of which a photograph is here produced (frontispiece). Over the scapulæ, in particular, and upon the shoulders the nodules are very numerous and large. There is no attempt at symmetry or grouping. Upon the buttocks and backs of the thighs and legs there are a few scattered lesions, but the legs below the calf are free of lesions. On

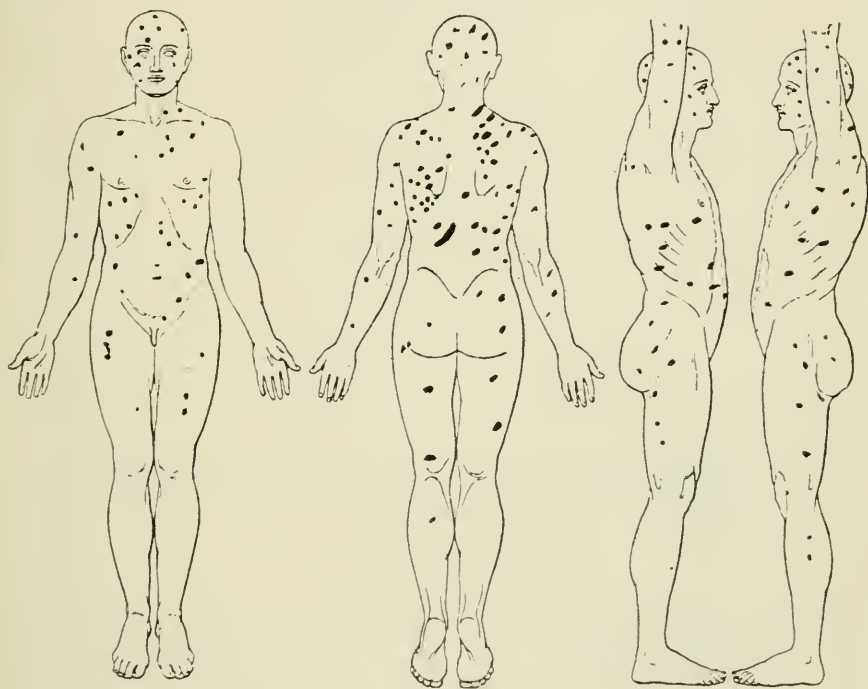


FIG. 11.

the front of the body the lesions are smaller and less numerous than on the back, and are very sparse upon the thigh, ceasing above the level of the knee. There are a few scattered nodules upon the flexor surface of the right arm and extensor surfaces of both arms and forearms; there are numerous nodules on the face, scalp, and neck; the palms, soles, and buccal mucous membrane are all free.

Condition of the glands.—The patient was lost to observation, owing to change of address, and the omission to note the condition of the glands at the earlier visits could not be rectified. A point of

considerable interest was noted in this case. The patient had an intercurrent attack of measles, and as an apparent result of this the nodules became sensibly flattened, and in certain instances entirely converted into macules.

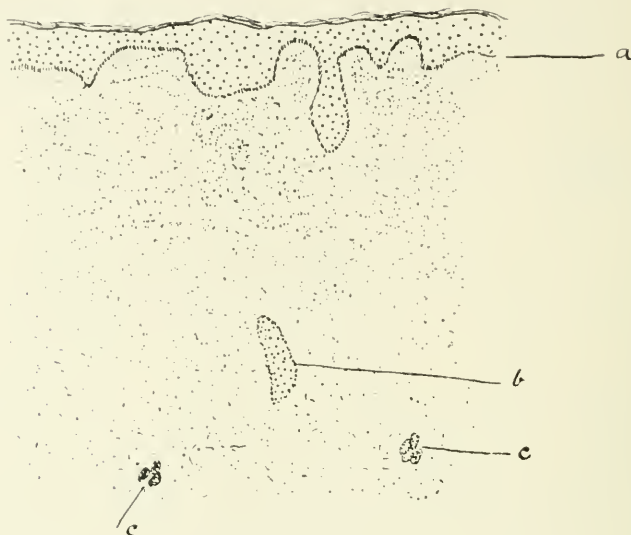


FIG. 12.—Stained with polychrome methylene blue + alum. Drawn with camera lucida ($\times 70$). *a*, Basal layer of epidermis with pigment-cells; *b*, portion of hair shaft; *c*, sweat-glands. The infiltration of the corium, figured above, is composed of mast-cells.

HISTOLOGY.

Edward W— (Fig. 12). Specimen of skin taken from the flank: a small dark nodule was excised entire. The epidermis is thinned and stretched over the tumour with no rugosity of the surface. The kerato-hyalin is deficient and in places entirely absent. There is much epithelial œdema, intra-cellular and interstitial.

Pigment-cells.—These are found in the basal layer of the epidermis and in some places in two or three of the superposed layers of the rete; the granules are few and are lighter in colour than in most of the other cases, notwithstanding that the nodule was clinically an especially dark brown. No pigment-cells are seen free in the corium.

Mast-cells.—In the earlier sections at the margin of the nodule the infiltration is seen to especially affect the blood-vessels of the interpapillary zone. Over the substance of the nodule, however, a general disseminated infiltration is found in which no special vascular distribution is noted. The skin, from the epidermis to the hypoderm, is uniformly and closely filled with mast-cells, which are usually cuboid in shape with scanty granular envelopes and considerable free *débris*. Here and there well-formed fusiform mast-cells are

visible. From the amount of the infiltration the colour of the section to the naked eye is predominantly red—the colour of the granules of the mast-cells.

Elastin and collagen.—Both elastin and collagen are completely displaced by the mass of mast-cells; the elastin is forced back and forms a thick felted barrier below the infiltration. The collagen is similarly dislocated.

(*To be continued.*)

SOCIETY INTELLIGENCE.

THE DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.

A MEETING of this Society was held on Wednesday, June 28th, 1905, Dr. H. WALDO (President) in the Chair.

The following cases were exhibited :

Dr. ALFRED EDDOWES showed (1) A case of *acute sclerodermia*. The lesion consisted of a single white patch, surrounded by a congested and slightly œdematous border, situated on the left side of the neck, and partly overlying the central portion of the sterno-mastoid muscle. Its margins were hard and thickened, and contrasted sharply with the neighbouring tissues. The patient was a young police officer, who stated that he had noticed the patch about five weeks previously. He supposed that his neck had been rubbed by the collar of his tunic.

Dr. Eddowes thought that the story of friction deserved attention, for, as the members might recollect, he had shown a case some years ago before the Society in which sclerodermia had occurred in a somewhat similar position, but along the line of the sterno-mastoid muscle, and had followed frequent rubbings with liniments for the temporary relief of toothache of long standing. In that case it appeared as though the skin had suffered most where it had received most friction between the underlying muscle and the superimposed hand of the operator with the liniments.

Mr. CAMPBELL WILLIAMS recalled the term "herpetiform morphea," as used by Hutchinson, and he thought that the posterior root ganglion was affected in this variety of sclerodermia as in true zona.

(2) A case of *X-ray burn and painful ulcer cured by an incision*. The patient was a young woman who had had lupus of the foot treated by X-rays twice a week for two years. When she came under the exhibitor's care, three months ago, she complained of severe pain in the area of the skin which had been so treated, and in the centre of the sclerosis thus produced was a deep painful ulcer which had existed for upwards of twelve months, still refusing to heal, except at its lower (*i. e.* distal) border, and even there the granulations were lumpy and pale.

The fact that the ulcer continued to break down at the upper part while it showed a tendency to heal at the lower border suggested to Dr. Eddowes that this latter area owed its power of healing to the destruction or severance of damaged nerve-fibres, such as were still living, and in a state of irritation causing breaking down in the upper portions of the ulcer. Therefore he imitated the action of the ulcerative process by making an incision sufficiently long and deep to include all the superficial nerve-fibres leading to the patch. The incision was necessarily crescentic in shape, and, lying transversely across the leg two inches above the ankle, passed nearly half-way round the limb. The central portion of this incision gaped over an inch, showing how great had been the tension in the sclerosed (burned) area.

Relief was immediate and permanent. The ulcer quickly healed, and the patient, having quite lost her pain, slept well and put on flesh.

A microscopic section taken from a portion of skin removed during the above operation showed that the X-ray treatment, after two years, had produced an increase of fibrous tissue, densely packed, with atrophy of epidermal structures, scarcely a trace of glands being found, and the blood-vessels were few and small.

Dr. GRAHAM LITTLE showed (1) a case of *Lupus erythematosus* in a woman, aged 50 years. This was an unusually interesting case, because it seemed to offer a combination of two types of the disease, the circumscribed variety and the disseminated, at the same time. Upon the scalp there was a large area of disease, about four or five inches in extent, and there was the usual follicular atrophy with shedding of hair over this part. There were also small circumscribed patches in front of the left ear, and in the conchæ of both ears. On the

malar eminences of both cheeks, on the nose, and on the forehead, there were much more recent patches of diffuse erythema, with a sense of burning or smarting; these patches had been present only a few weeks, while the older ones had been noticed for periods dating back from three to six months. There were no other lesions on any part of the body. There was an excess of phosphates in the urine, but no albumen. She had well-marked, small, punctate, red areas on the mucous membrane of the right cheek. The prognosis of this case was considered serious in view of the rapidly increasing and vividly erythematous nature of the recent patches. It might be of interest in this connection to mention that the case of disseminated acute Lupus erythematosus shown to this Society in November, 1904, by the same exhibitor, had recently died with symptoms of acute phthisis.

(2) A case of *juvenile flat warts* on the face and hands, in a girl, aged 13 years. On the upper lip there was an oblique, linear arrangement of these warts, which were here more filiform than elsewhere. The linear grouping was not common in the experience of the exhibitor, but he had quite recently seen another very marked example of the condition in a boy at St. Mary's Hospital. It was probable that the warts arising in this manner were the result of auto-inoculation of a wound such as would be caused by a scratch with a finger-nail of the subject.

MR. WILLMOTT EVANS had seen cases in which warts had developed upon lines of injury, especially after scratching. He had found the treatment with magnesium sulphate internally very satisfactory.

DR. MANNERS-SMITH exhibited a case of *Fordyce's disease*. The patient was a girl, aged 21 years. She had a large number of aggregated, whiteish, sago-grain-like bodies beneath the mucous membrane of the lips, and some of a smaller size on the inner side of the cheeks.

It has been shown by Hay and Montgomery that these little bodies, described by Fordyce, are enlarged, persistent, sebaceous glands, and it was these observers who first called attention to the occasional presence of sebaceous glands within the mouth. Most of the cases hitherto described have been in males. In America the condition is said to be far from uncommon, especially in negroes. The affection gives rise to no trouble, though in some cases there has been co-existing stomatitis. It is little influenced by treatment.

Dr. NORMAN MEACHEN showed a *case for diagnosis*. The patient was a widow, aged 41 years, who had presented herself at the skin department of the Tottenham Hospital with "sore places at the ends of the fingers like warts." The condition had been noticed for six months. She was a pale, nervous woman, not addicted to alcohol, engaged, since her husband's death, in office-cleaning. There was a mitral systolic bruit at the apex. The lesions consisted in small depressed areas, with roughened bases, resembling the surface of an ordinary wart, situated at and around the tips of the fingers of both hands, undermining, in some of the fingers, the free border of the nail. The margins of these areas were irregular and presented an eroded appearance, yet the sunken areas were not sodden, as is usually seen in the secondary lesions of dysidrosis. The patient, nevertheless, stated that the hands did sweat considerably, but she chiefly complained of an aching and throbbing sensation in the finger-tips, especially at night. The nails themselves were fairly normal, being neither pitted nor ridged.

The general opinion was that the condition was one of secondary infection upon a hyperidrotic basis, though no member felt disposed to give the affection a name.

Dr. V. H. RUTHERFORD exhibited the patient with *rodent ulcer* that he had first brought before the Society in March (vide *British Journal of Dermatology*, May, 1905, p. 186), in order to demonstrate the satisfactory cure obtained by twenty-five exposures to the X-rays. Seven weeks had elapsed since the ulcer healed.

CLINICAL NOTE.

CASE OF PEMPHIGUS NEONATORUM GANGRENOSUS.

By W. T. FREEMAN, M.D., F.R.C.S.

I was called by the midwife on July 21st of this year to see a male infant a few hours old, who was said to have no skin on his feet and legs. It was a well-nourished and, where the bullæ were not, a clean-skinned baby. There was nothing in its appearance to denote a syphilitic cachexia.

Extending from the inner side of the right instep over the ankle and up the inner side of the leg to the knee was what was practically one long bulla, partly empty below owing to peeling of the epidermis, and more or less filled with blood-stained serum in the upper portion. Another large bulla occupied a nearly similar position on the left leg. For a few moments, and until I stripped the infant, I thought possibly there had been undue dragging force exerted upon the legs in a troublesome breach case. This opinion I was quickly able to put aside, for I found bullæ with hæmorrhagic contents and from about the size of a threepenny-piece to half a crown scattered over various parts of the body; the groins and buttocks and back were particularly affected; there was a large one on the left cheek and others of smaller dimensions on the face generally. I noticed but one bulla on the hands, on the left index finger near the nail. The child only survived its birth for four days, and until the fourth day was able to take the breast. During its short existence a few of the bullæ nearly dried up; in others the epidermis ruptured, leaving ugly patches of blood-stained corium which soon began to assume a gangrenous appearance. The patient looked desperately ill only during the last few hours of his existence, and the temperature was then raised to above 102° F. It is the first case of the kind that I have met with in my practice, and was evidently of a much more severe type than the ordinary Pemphigus neonatorum of authors. The mother remains well. The midwife, looked after both the mother and child, and any future developments will be watched for. Unfortunately, the contents of the bulla were not examined.

There are two points in the family history that may bear upon the case: (1) The father is the subject of severe asthma of many years' standing. (2) Another child is suffering from the effects of cornual myelitis and is still paralysed and has a club foot, etc.

The case possibly corresponds with those that have been described under the heading of "*Dermatitis exfoliativa gangrenosa*."

As cases of this kind have been said to run into epidemics, organisms, possibly of a special kind, must sometimes have a part in their continuance, if not in their production; but I am inclined to think myself that the skin-eruption is but a peripheral expression of a widespread central nervous lesion, and that the epidemics, if

epidemics there be, are caused by a secondary infection of the contents of the vesicles.

One other point is worth recording, that nine parts out of ten of the eruption were present at birth, or at all events when I first saw the case; only a few comparatively small bullæ developed during my attendance.

CURRENT LITERATURE.

THE LIFE CYCLE OF THE ORGANISM OF "DERMATITIS COCCIDIOIDES." S. B. WOLBACH. (*Journ. Cut. Dis., including Syph.*, January, 1905.)

FROM the forty or so cases included in the clinical group the organisms recovered have varied greatly. Hyde and Montgomery believe that they may have to be classified in several "distinct botanical groups," whilst Ricketts concludes that the seventeen organisms studied by him may be classified as belonging to three varieties of the genus *Oidium*, viz. blastomycetoid or yeast-like, *Oidium*-like, which may produce by budding, and hyphomycetoid. In pure cultures they grow either as a mycelium, not yet properly classified, or as a budding fungus, *Torula*. The material studied by Wolbach was obtained from a case occurring in the practice of Dr. W. P. Bolles, of Boston, U.S.A., and the clinical aspects of the case will be reported later. The lesions were subcutaneous, and on the forehead and mastoid involved the bones. The patient had travelled extensively abroad, and lived in California and Mexico. Identical cultures, resembling young colonies of *Oidium lactis*, were obtained directly upon glycerin agar from tissue removed at operation and indirectly from a subcutaneous abscess produced by inoculation of a rabbit. Microscopically the cultures were composed of a radiating mass of coarse, branching, occasionally segmented mycelia with a distinct membrane. Very old colonies acquired an aerial hyphæ-bearing gonidia, and at this stage great numbers of spherical bodies are found resembling those in tissue. The latter do not show budding, though the picture is sometimes simulated. In guinea-pigs and rabbits lesions were produced very similar to those occurring in tuberculosis, and going on to necrosis and pus-formation, in which were found spherical bodies undergoing endogenous reproduction. The mycelium is never found in lesions. Mallory's eosin and methylene blue stain is recommended as the best for demonstrating the organisms.

Segmentation of the spheres with a finely granular protoplasm commences by a peripheral division of the protoplasm, which, extending inwards, results in a mass of polyhedral segments, separated from one another by clear spaces, and later becoming spherical or oval and surrounded by a hyaline eosin-staining matrix. These segments or spores are liberated by the breaking of the capsule of the mother cell, and are separated but preserved in groups by the ingrowth

of the inflammatory tissue. The production of mycelium (one to eight filaments) may be seen to grow from a sphere on special agar preparations. The change from filaments to spheres was demonstrated by (1) intra-venous inoculation of rabbits, and (2) introducing into the peritoneal cavity of rabbits pure cultures sealed in collodion capsules.

The writer says the organism obviously cannot be a blastomycosis, and, though most closely resembling the *Oidium*-like type of Ricketts, it is excluded by the absence of budding.

Three interesting plates illustrate the paper.

T. C. F.

OBSERVATIONS CONCERNING SOME PALMAR ERUPTIONS.

HENRY W. STELWAGON. (*Journ. Cut. Dis., including Syph.,* January, 1905.)

IN this paper, read before the fifth International Dermatological Congress, the author discusses some points in connection with the chronic, dry, scaly phases of eczema (*E. seborrhoicum*) and syphilis of the palmar aspects of the hands, in which the eruption seems wholly independent of recognisable external agency. They are rarely seen in his experience under 25, and seldom under 30, years of age. The circulatory system is frequently weakened, especially from heart trouble primary or secondary to renal trouble. There is commonly some anæmia, and the patients lead a sedentary life. Females are much less liable than males. A marginate border, especially if serpentine or crescentic, excludes eczema but not Eczema seborrhoicum. In the latter, however, the morbid process is more superficial, as a rule, yet in some syphiloderms the infiltration is very slightly marked. Scalps are so frequently seborrhoic that too much stress must not be laid on the concurrence of this symptom; the presence of Eczema seborrhoicum of the trunk is more reliable. A sharply marginate, crescentic, or serpiginous eruption of *one* palm alone is almost invariably syphilitic. A history of syphilis is suggestive but does not definitely settle the diagnosis. Itching usually points to eczema.

These affections are very intractable. For the type of eczema referred to Stelwagon recommends salicylic acid ointment (10-20 per cent.), salicylic acid plaster (5-15 per cent.), washing with *sapo viridis*, solution of caustic potash (1-5 per cent.) alternated with a mild unguent. In some cases the X-rays are very successful. In some measure Eczema seborrhoicum is amenable to similar remedies, but the green soap and caustic potash are of much less value. Occasional painting with alcoholic solution of resorcin (10-50 per cent.), sulphur (5-25 per cent.), chrysarolin (2-10 per cent. in lard and petroleum) are good. For the treatment of the chronic dry palmar syphilides he strongly recommends the administration of mercury by *inunction* or *hypodermic injections* in full to enormous doses, as local remedies and a mild mercurial course and potassium iodide often prove useless. The circulation should be improved in every way possible.

T. C. F.

A CASE OF MYCOSIS FUNGOIDES. HARVEY P. TOWLE. (*Boston Med. and Surg. Journ.,* December 8th, 1904.)

THE case was reported from the Massachusetts General Hospital. The patient was a female, aged 62 years, whose family and previous histories were negative. The disease began twenty-three and a half years ago as a palm-sized red patch

on the outer side of right thigh. This disappeared spontaneously. Later other spots—one of which was vesicular, and the rest scaly and slightly indurated—appeared, and also disappeared, but more slowly, and for the last eight or nine years none which have appeared had disappeared. Three years ago ulceration occurred in a patch on the left knee. A year ago tumours appeared, chiefly on the extremities. There was marked thinning of the hair everywhere. The diseased patches were universal in their distribution, the affected skin being thickened, red, and scaly. The tumours were generally oval, with rounded tops projecting a quarter to half an inch above the patches (or healthy skin where they occasionally occurred), and measuring 2 or 3 inches by $\frac{1}{2}$ or 1 inch; some of these looked comparatively solid, others had a macaroon-like appearance. Over the left patella and just above it were two ulcers. A blood-count showed polynuclears 63·5 per cent., lymphocytes 32·5 per cent., eosinophiles 4 per cent. The tumours microscopically showed great hyperplasia of the rete, but no infiltration of the corium. The ulcers and many of the tumours disappeared under X-rays, and the application of salicylic acid plasters seemed to be beneficial.

G. S.

FURTHER OBSERVATIONS ON MULTIPLE BENIGN SARCOID.

C. BOECK. (*Archiv f. Derm. u. Syph.*, January, 1905, lxxiii, p. 71, and February, 1905, p. 301.) Two plates.

SINCE the earlier communications on the subject of "multiple benign sarcoid" which Boeck first described in 1899 in the *Norsk Magazine for Lægevidenskaben*, four true cases have been recorded by Forchhammer, Gottheil, Hallopeau and Eck, and Hallopeau and Pelagatti. Darier also has seen several cases. In this contribution Boeck describes five additional cases. In Case 1 the patient, a male, aged 33 years, suffered from the nodular form of the disease. The nodules, which varied from the size of a pea to that of a bean, were reddish-blue in tinge and situated on the right cheek, shoulder, and arm. The elbow-glands were swollen. One of the nodules was excised for microscopical examination. Case 2 belonged to the diffuse type of the disease. The patient was a woman, aged 41 years, and brownish-yellow finely scaly lesions and small nodules were present on the side of the nose and cheeks. Arsenic was prescribed internally and great improvement resulted. In Case 3, also a woman, aged 41 years, the lesions were situated about the bridge of the nose, and consisted of brownish-yellow nodules about the size of pins' heads. This case also reacted to arsenic. Injections of tuberculin did not cause any local reaction, though there was a slight febrile disturbance which lasted for a few days. In Case 4 the patient was a young woman, and the nodules were present on the forehead, cheeks, and bridge of the nose. In Case 5 the patient was a woman aged 18 years, and the nose and left cheek were involved. The nasal mucosa was swollen and infiltrated, but not ulcerated. A microscopical examination was made of the nasal mucosa, and revealed a diffuse infiltration consisting of plasma-cells, ordinary connective-tissue cells and leucocytes. Bacilli like those of tuberculous were found in the tissue. A piece of tissue was inoculated into a guinea-pig which was killed two and a half months later, when an enlarged axillary gland was found, in which were numerous bacilli, undistinguishable from tubercle bacilli. The course of the disease does not, however, suggest tuberculous, and the fact that it is so amenable to arsenic is also against that diagnosis.

J. M. H. M.

THE VACUUM TREATMENT OF LUPUS. SONDERMANN. (*Monats. f. prakt. Derm.*, January 1st, 1905, p. 1.)

THE method is a modification of Bier's treatment of Lupus by means of inducing hyperæmia. For the treatment to be successful the method must provide for the easy induction of hyperæmia over long periods and every day, if necessary. Hyperæmia is here produced by fitting a modified inhaler facepiece over the diseased area and creating a vacuum inside it by means of an indiarubber ball provided with valves and connected to the *quasi*-facepiece by an indiarubber tube.

A further modification of this apparatus allows the diseased area to be irrigated at will by any desired fluid at the same time. The apparatus is simple and requires very little skilled supervision.

Bier himself appears to be somewhat sceptical as to the final success of any hyperæmic treatment in Lupus as compared to other methods, although he has obtained good results in some cases.

J. L. B.

SUBCUTANEOUS INJECTIONS OF CHAULMOOGRA OIL IN LEPROSY. TOURTOULIN BEY. (*Monats. f. prakt. Derm.*, January 15th, 1905, p. 88.)

ALTHOUGH chaulmoogra oil gives better results in leprosy than any other medicine taken internally, it must be taken for a long time and in large quantities before producing good effects. In 1894 Tourtonlin tried it as a subcutaneous injection in doses of 5 grammes, the first patient receiving as many as 584 injections in five years, and deriving great benefit from them. In 1890 the case was communicated to the Société de Dermatologie, and Hallopeau was appointed referee. He acknowledged the great improvement in the patient, but was not inclined to ascribe it entirely to the oil. In 1901, however, he reported that subcutaneous injections of the oil gave good results in leprosy, and that nine cases which he had treated with the oil, some subcutaneously, some internally, had, with one exception, all benefited. Du Castel has treated four cases with subcutaneous injections and they all improved, Miguel seven cases and all improved: the infiltration diminished, the nodules disappeared, purulent discharge ceased, sensation returned, nails grew again, joints became flexible once more, and one patient regained his sight to a certain extent. Miguel found that the improvement began to show itself in most cases after the fifth injection, although the patients' hygienic conditions were bad. The oil then appears to have beneficial effects when given subcutaneously, and of course it cannot produce any digestive disturbances when thus administered.

It has, however, been urged that certain disadvantages attach to the injections, that they may be painful and be the cause of a rise of temperature or even of pulmonary embolism. It is true, Tourtoulin says, that the injections may be painful; but in 900 injections he has only four times seen pulmonary embolism, as shown by difficult breathing, pallor, and diminution of pulse volume, symptoms not sufficient to definitely prejudice this method of treatment. Of course the injections must be given with every care and every attention to asepsis, avoiding the neighbourhood of large diseased vessels, where a drop of the oil could enter

the vascular system and cause an embolism. The subcutaneous tissue of the forearm or leg is the best place for injection. The treatment is, however, a lengthy one, and it is easy to believe that a cure has been effected when it has not, as shown by the reappearance of leprosy lesions if injections are ceased for 5 to 6 months, although in a milder form. The injections must be continued for years, but it is a great thing to obtain even a close resemblance to cure in such a hideous disease.

J. L. B.

THE CONNECTION BETWEEN TERTIARY SYPHILIS AND TABES DORSALIS AND PARALYSIS PROGRESSIVA. GUSZMAN and HUDOVERNIG. (*Monats. f. prakt. Derm.*, January 1st, 1905, p. 4.)

THE cases investigated were 50 in number, and consisted of syphilis of more than three years' duration; 24 were males, 26 females. The tertiary manifestations were in the majority of cases confined to the skin, but 8 cases had affections of the mouth, nose, and throat, and 1 case muscular changes. No bone disease was present in any of the cases. Specific changes of the eye or internal organs were excluded on account of possible uncertainties of diagnosis. A peculiar result of the investigation was that the figures pointed to increased chances of nervous disease among those who had previously undergone a satisfactory antisyphilitic treatment as compared with those who had had a less thorough treatment. The figures, moreover, did not point to any influence of heredity upon increased rapidity of development of nervous disease. The shortest interval between infection and commencement of nervous disease, namely one year, occurred in an individual who had undergone thorough treatment, whilst the longest interval, twenty-seven years, occurred in an individual who had scarcely had any antisyphilitic treatment. Among those who had had no previous antisyphilitic treatment occurred one interval of 19 and one of 13 years.

Among these tertiary syphilitics who had contracted their syphilis more than three years previously, a healthy nervous system was found in only 44 per cent. of the cases, whereas tabes dorsalis, progressive paralysis, and tabo-paralysis occurred in 46 per cent. or, including suspicious cases, in 54 per cent. The authors conclude that the connection of these diseases with syphilis is certain and open to no doubt. This connection could only be overthrown by demonstrating a similar relation of these diseases to some other affection of a non-syphilitic nature. Heredity is a predisposing cause, and syphilis tends to develop its action on the nervous system more effectually in neuropathic individuals than in those whose nervous system was originally sound.

J. L. B.

RECOGNITION OF A RECENT SCAR FOLLOWING PAPULO-TUBERCULAR SYPHILIDE. JOHANNES FICK. (*Monats. f. prakt. Derm.*, February 15th, 1905, p. 175.)

THE histological appearances of such a scar as described by the writer are peculiar in that they show an unusual condition of the lymphatic vessels of the cutis. Round the lymph-vessels in many places, as well as round the blood-vessels, the mononuclear leucocytes, mixed with plasma-cells, formed a perivascular infiltration. Giant cells of the Langhans type were also found in these perivascular cellular collections containing epithelioid cells and a few leucocytes.

The fixed connective-tissue cells were markedly increased in the whole cutis and especially in the tissues nearest to the epidermis.

In numerous lymph-vessels of the upper portion of the stratum reticulare were found masses of cells, composed partly of leucocytes, partly of epithelioid cells closely resembling those occurring outside the vessels. These cells had a somewhat indefinite contour and showed in their finely granular, faintly-stained protoplasm a bladder-like nucleus, which stained considerably less deeply than the nucleus of the leucocytes. This mass of cells did not entirely fill the lymph-vessel, but in many cases seemed to lie entirely free in the lumen, with a definite space between it and the vessel-wall. The masses were either roughly circular or elongated, and examination of further sections showed that they were connected with the endothelium of the lymphatic—in fact, they were outgrowths of the endothelium into the vessel lumen, and hanging free in it. The same appearances were found in numerous lymphatics. That these were not lymph-spaces of the connective tissue which had apparently enlarged until they resembled lymph-vessels owing to shrinking of the tissues was shown by the definite connection of the cell masses with the endothelium of the lymphatic and by the definite endothelial lining of the space.

If the cellular masses did grow from the lymphatic wall, their epithelioid cells could not grow from its endothelium, since the two were morphologically different. But inasmuch as these intra-vascular cell-masses nearly resembled the extra-vascular cell-masses of epithelioid cells, it is possible that they were respectively outgrowths of the intima and adventitia—in fact, young connective-tissue cells of these constituents of the lymphatic wall. Whether they were destined to degenerate or develop into fixed connective-tissue cells the sections did not show. The connection of these appearances with syphilis does not appear certain, and it will be interesting to see whether similar observations are made in other cases, especially if the details of preparation of the sections are given.

J. L. B.

EPITHELIOMA WITH SYPHILIS OF THE MOUTH. CH. AUDRY. (*Journ. des Mal. Cut. et Syph.*, April, 1904, p. 264.)

SYPHILIS AND CANCER OF THE MOUTH. CH. AUDRY. (*Journ. des Mal. Cut. et Syph.*, July, 1904, 487.)

AUDRY relates a case in which syphilitic lesions of the cheeks, of the tongue, and of the larynx were cured by mercury, except at one point. At this point there had been a deviation from the process of acanthosis producing the so-called papillomatous condition at other parts, a condition so frequent in chronic syphilitic and tuberculous lesions. Here it had passed the limits of a simple acanthosis and had become epitheliomatous.

In the second communication Audry briefly gives some indications of the manner in which cancer may arise in syphilitics; he suggests three categories:

- (1) Syphilis, leucoplasia, epithelioma.
- (2) Syphilis, epithelioma on the lingual or buccal mucous membranes showing stigmata certainly or probably of syphilis (ciatrices, etc.) other than leucoplasia.
- (3) History of syphilis, epithelioma.

He suggests that certain epitheliomata of the rectum are also developed upon syphilitic lesions.

H. G. A.

BLACK PENIS ("VERGE NOIRE") DUE TO ANTIPYRIN ERUPTION. HENRI MALHERBE (Nantes). (*Journ. des Mal. Cut. et Syph.*, July, 1904, p. 499.)

M. X—, aged 30 years, subject to migraine for fifteen years, for which he had been accustomed to take antipyrin in doses of 1 to 2 grammes. One day some hours after taking a customary dose (1½ grammes), he was startled to find the penis completely black. Malherbe recognised the condition as one previously described by A. Fournier, who reported three cases in the *Annales de Dermatologie* in 1899 (p. 371). Apart from the blackness the skin appeared perfectly normal. This affection is comparable with the fixed erythematopigmented eruptions described by Brocq. Fournier has called the eruption "verge noire"; he notes that it may occur without other disturbance, or it may be accompanied by oedema of the prepuce and phimosis. "Verge noire" may therefore appear when the patient has long been accustomed to take antipyrin without inconvenience. It usually takes a very long time to disappear. It does not necessarily recur after subsequent doses.

H. G. A.

REVIEWS.

ELEMENTARY MANUAL OF TOPOGRAPHICAL DERMATOLOGY (REGIONAL).*

THE object of this manual on dermatology is to present to the general practitioner and student a short description of the diseases of the skin as they affect the different regions of the body. Each region is discussed in a chapter which contains a concise description of the salient clinical appearances and treatment of the various dermatoses which may attack that region. For example, supposing a patient comes up for treatment suffering from a dermatitis chiefly involving the hands, the practitioner has simply to turn up the chapter on the hands and read over the list of skin diseases of the hands at the beginning of the chapter, and having decided which of these his patient is suffering from refer to the short description of it which the chapter contains. Instead of an index several charts of the surface of the body are furnished, which are mapped out in different regions and numbered according to the first page of the chapter dealing with that region. These show at a glance where to find the description which is desired. The descriptions of the diseases are brief but lucid, and the clinical features are illustrated by excellent reproductions of photographs of Sabouraud's patients, by Noiré, and of the plaster casts in the St. Louis Hospital. It is interesting to note as a sign of the times that in the pages devoted to the discussion of *Tinea tonsurans* the X-ray treatment alone is seriously considered. As far as we know, this arrangement is original, and it has the great advantage

* *Manuel Élémentaire de Dermatologie Topographique (Régionale)*. By R. SABOURAUD. Paris: Masson and Company, 1905. Pp. 756. Price 15 fr.

of avoiding the difficulties associated with the problems of classification. Its obvious defect is that an arrangement of this sort necessitates much repetition and overlapping, furnishes a superficial knowledge of the diseases under consideration, and its value diminishes as the student's knowledge of dermatology increases. In all fairness, however, to the author, it must be conceded that the book does not profess to be anything more than a practical manual of diseases of the skin for the busy practitioner, and as such it will prove of undoubted value.

DISEASES OF THE SKIN.*

THE third edition of Dr. Radcliffe-Crocker's text-book was published early in 1903, and perhaps the only unfavourable criticism which might have been made of it was that, considering the importance of the book—for it is the recognised English text-book on the subject—it was insufficiently illustrated, and in this respect did not come up to the standard of several of the American text-books. This defect has now been obviated by the addition of about seventy new illustrations. The majority of these are taken from photographs of patients, while a certain number of them are reproduced from the author's atlas. The production of these illustrations leaves little to be desired, and some of them have exceptional merit. Most of them are selected to illustrate the more common affections of the skin. For example, there is a series of full-page reproductions illustrating Lupus vulgaris, psoriasis, eczema, leprosy, syphilis, and the various types of alopecia. Amongst those of special interest, owing to their rarity, are the illustrations of *Dermatitis repens*, *Psoriasis rupioides*, *morphea* in the course of the supra-orbital nerve, *Myoma multiplex*, *Lymphangiectodes*, and *Xeroderma pigmentosum*. By the addition of these illustrations the value of this edition of the text-book has been greatly enhanced.

INTRODUCTION TO THE MICROSCOPICAL STUDY OF THE NORMAL AND PATHOLOGICAL SKIN.†

IN this monograph of a hundred pages the authors have briefly described the technique for the histological study of the skin, its minute anatomy, and the pathological changes which may affect its elements. The description of the technique though brief is adequate, that of the histology is clearly written and up-to-date, but that of the pathological changes might with advantage have been more complete. The monograph is of special interest, as it embodies the teaching of one of the best known skin-histologists, Professor Ehrmann, and it is based on his course of lectures on the subject. As was to be expected, the subject of the origin of pigment is discussed at considerable length. Ehrmann's views upon it may be thus summarised: (1) That melanin is intra-cellular, and in the situations where it is present occurs in the deeper layers of epidermal cells and in certain mesoblastic cells known as melanoblasts; (2) that melanoblasts are

* *Diseases of the Skin*. By H. RADCLIFFE-CROCKER. Third edition, 2 vols., with 74 plates. London: H. K. Lewis, 1905. Price 30s. net.

† *Introduction to the Microscopical Study of the Normal and Pathological Skin*. By S. EHREMAN and JOH. FICK. Vienna: Alfred Hölder, 1905.

specialised connective-tissue cells which are round, spindle-shaped, or branching, and are peculiar not only in containing melanin granules, but also in having larger nuclei which stain more faintly than those of ordinary connective-tissue cells; (3) that melanoblasts occur in the upper layers of the corium, are specially noticeable around the blood-vessels, and are also present as peculiar branching structures in the inter-epithelial lymphatic spaces of the deeper portion of the epidermis; (4) that melanin is a derivative of blood-pigment, the material from which it is formed getting out of the blood-vessels into the peri-vascular tissue-spaces, where it is taken up by the melanoblasts and transformed into melanin; (5) that the epidermal cells do not elaborate melanin, but absorb it from the melanoblasts in the inter-epithelial lymphatics.

The text is illustrated by a number of drawings of histological structures, some of which are complete or partial copies of illustrations by Rabl, MacLeod, and Flemming. There is also a coloured plate with three drawings showing respectively collastin, elacin, and a cellular infiltration in the corium of plasma-cells, connective-tissue cells, leucocytes, and mast-cells.

TRANSACTIONS OF THE AMERICAN DERMATOLOGICAL ASSOCIATION AT ITS TWENTY-EIGHTH ANNUAL MEETING.*

THE twenty-eight annual meeting of the American Dermatological Association was held last year at Niagara Falls, and to judge from the Official Report of the Proceedings by the Secretary the meeting must have proved an unqualified success. The matter contained in this report is already more or less familiar to the readers of the *Journal of Cutaneous Diseases*, but to those who do not have the opportunity of seeing our American contemporary regularly, it may be of interest to refer briefly to the papers which formed the subjects for discussion at the different sessions of the meeting. The president for the year was Dr. Joseph Zeisler of Chicago, and the first session was opened by an introductory address by him, in which he dwelt specially on the great importance of presenting as much clinical material as possible at such meetings, and advocated the curtailing of papers by the readers of them simply describing to the meeting the salient features of their communications, and leaving the details to be read when the papers were published *in extenso*. After the presidential address Drs. Grover W. Wende and Charles A. Bentz contributed a paper on "Rhinophyma—a Pathological Analysis of Five Separate Tumours occurring in the same Patient"; Dr. M. B. Hartzell discussed "Granuloma Pyogenicum" (Botryomycosis), and Dr. Henry W. Stelwagon described "A Peculiar Eczematoid Eruption of the Lip Region." The last contribution gave rise to considerable discussion. Several of the members were of opinion that the condition described was either a late syphilide or a seborrhoic eczema super-imposed on syphilis. Dr. Stelwagon would not admit of this diagnosis, and reported that he had prescribed specific treatment in several such cases with absolutely no effect on the lesions. Dr. W. T. Corlett contributed "Notes on Certain Post-vaccinal Eruptions," illustrated by a series of photographs, and Dr. W. F. Breakey described "Parasitic Sycosis communicated from Cattle."

* *Transactions of the American Dermatological Association at its Twenty-eighth Annual Meeting*. Official Report of the Proceedings by CHARLES J. WHITE, M.D. New York: The Grafton Press, 1904.

An instructive paper by Drs. Nevins Hyde and Ernest L. McEwen, "On the Relation of certain Dermatoses to each other, and to Changes in Vascular Equilibrium," closed the first session of the meeting.

At the evening session Dr. Hermann G. Klotz described "A Case of Re-infection of Syphilis," and Drs. D. W. Montgomery and Howard Morrow discussed the "Reasons for Considering Dermatitis Coccidioides an Independent Disease," and the following points were considered to be characteristic of coccidioides and coccidioidal infection, as against blastomyces and blastomycetic infection: (1) the cultures are characteristic; (2) the organism has a double cycle of development, the one cycle differing absolutely from the other; (3) there are no budding forms either in the cultures or in the tissues; (4) there is endogenous spore formation in the tissues, and this appears to be the sole mode of reproduction in the tissues; (5) the capsulated bodies are comparatively large and are almost always circular; (6) in animal experiments the testicle is a favourite seat of the disease; (7) the infection tends strongly to become generalised; (8) the prognosis is absolutely bad; and (9) the administration of iodide of potassium has no control over the disease. In the discussion which followed Dr. Caspar Gilchrist considered that the evidence adduced by Drs. D. W. Montgomery and Morrow was inconclusive, and that they had not made good their case, and he believed that the type of case described by these observers under the heading of "Dermatitis Coccidioides" belonged to the blastomycetic group.

Dr. J. C. White contributed "Some Notes concerning Domestic Remedies formerly used in Skin Diseases," and Dr. Henry H. Whitehouse wrote on "Xanthoma Multiplex: Histology of the Palmar Striae." Dr. T. Caspar Gilchrist made a further communication on the subject of "Erysipeloid, with a record of 329 cases, of which 323 were produced by crab bites or lesions produced by crabs."

The morning session of the second day was devoted chiefly to a discussion on the "Affections of the Mucous Membranes in their Relation to Skin Diseases," which was opened by papers by Drs. J. A. Fordyce and M. F. Engman. Referring to the "peculiar affection of the lips" which he originally described, Fordyce stated that he originally believed it to result from a degenerative change in the epithelium of the affected part, but now considered it to be due to the presence of sebaceous glands in the lips. In this connection it is of interest to note that in the March issue of the *Journal of Cutaneous Diseases*, a series of 65 cases of Fordyce's disease are recorded by Charles J. White, and in this discussion on its pathology he reverts to Fordyce's original opinion that it is an epithelial anomaly consisting histologically of acanthosis, œdema, and parakeratosis, and that although sebaceous elements are present, they lie beyond the diseased tissue proper. Dr. Ravogli next contributed a paper on "Lichen Planus Verrucosus," and Dr. J. F. Schamberg one entitled "An Inquiry into the Etiology and Nature of Toxic Erythemata," and Dr. W. A. Hardaway gave "A Further Report of a Case of Multiple Myomata of the Skin." In addition to the discussions and papers, a number of interesting cases and photographs of cases were demonstrated. Among the former were cases of multiple idiopathic pigmented sarcoma, Epidermolysis bullosa hereditaria, and blastomycetic dermatitis.

LIGHT ENERGY.*

THIS treatise on Light Energy, its physics, physiological action, and therapeutic applications, is the first systematic text-book on the subject which has yet been published. It is the result of eleven years of patient research and clinical experience, and is a record of careful observation supplemented by detailed references to the more important contributions to the subject. The earlier chapters are devoted to the consideration of light in its physical aspects, and the manifestations of light energy, radiant heat, brush discharges, and visible and invisible rays are discussed. The action of light on the elementary forms of life, especially on bacteria, is next considered. This is followed by a chapter on the action of light on the higher organisms, with special reference to its effect on the skin, circulation, nervous system, and metabolism. The value of sunlight in the treatment of disease is fully considered both in the form of diffuse sunlight, sun-baths or solaria, and concentrated by means of lenses.

The construction of the electric arc bath is fully described and its therapeutic indications discussed. "In the writer's personal experience the non-concentrated light energy of the carbon electric arc has been found of great value, in both primary and secondary anemias, malnutrition, neurasthenia, in neuritis, and neuralgias. In no one condition is it of greater value than in tuberculosis of the lungs."

There is an interesting chapter towards the end of the book on the action of light on super-sensitive skins, in which special reference is made to Xeroderma pigmentosum, Pellagra, and Hydroa aestivale.

The illustrations throughout are good. The work should prove of great value to all those specially interested in photo-therapy.

TROPICAL LIGHT.†

THE proof of the theory that the pigmentation of the skin of man was evolved as a protection against the harmful action of the actinic rays of light forms the *raison d'être* of this monograph. It is somewhat remarkable that a theory which is so obviously true, that it has been accepted for years by almost everyone who has given any thought to the matter, should have required in these days a volume such as the one before us to prove it conclusively, yet with a few more or less relevant digressions, this forms the subject matter of some 300 pages. In the reading of these there is the consciousness of the ancient truth that "of the making of books there is no end, and much study is a weariness of the flesh." In that the author accomplishes his task he is to be congratulated, and he has given much information of interest in the doing of it on such matters as the adjustment of man to his environment, the physical problems of light, the action of the ether waves on protoplasm, the natural defences of animals from light, and the results of insufficient pigmentation. But would that the information were more accurate, and such statements as the following can scarcely stand scrutiny—that "man

* *Light Energy*. By MARGARET A. CLEAVES, M.D. London: Rebman, Limited, 1904. Price 21s.

† *Tropical Light*. By Major CHAS. E. WOODRUFF, A.M., M.D. London: Rebman, Limited, 1905. Price 10s. 6d.

is invariably covered with pigment," and that "Finsen cured nearly all his cases of localised superficial bacterial (though chiefly tuberculous) infection of the skin by concentrated actinic rays, and most of his cancer cases." The most useful chapter in the book is the last one, which is entitled "Practical Rules for White Men in the Tropics." This is a subject, though irrelevant to the argument of the book, concerning which the writer's experience as an officer in the American Army renders him competent to deal with, and the chapter contains much valuable information for those who have to change their habitat from a temperate to a tropical country.

SYPHILITIC ARTERITIS.*

IF excuse were needed for the publication of this work it is afforded, as the author points out in his preface, by the importance of the subject, not only to the syphilographer or the dermatologist, but to the neuro-pathologist, ophthalmologist, laryngologist, and to all who are interested in diseases of the lungs, heart, liver, or kidneys. In an introductory chapter the author shows how syphilis of the arteries, suspected by the ancients, has been discovered and fully studied for fifty years. Syphilitic arteritis occurs either (1) in association with other tissue lesions, in the syphilomata of every kind and period, and then generally in the arteries of small calibre, or (2) as a relatively isolated condition affecting the vessels of large or medium calibre.

In the first variety (associated arteritis), it is seen in the chancre, in which it is, according to Rieder's researches, preceded by venous and lymphatic changes, and in all the secondary and tertiary manifestations, which, whatever be their nature and their site, have endo- and periarteritis as the most constant and characteristic element of the lesions. In the second variety of pure syphilitic arteritis, the proof of the syphilitic nature of the lesions is found in the relative youth of the subjects attacked; the absence of other known causes of arteritis; the existence of a previous syphilitic infection; the efficacy of specific treatment; the frequent localisation to certain determined arterial territories; and lastly the anatomical type of the lesions.

Syphilitic arteritis is classically considered as a manifestation of the tertiary period; in fact, arterial lesions considered *en bloc* are most often met with between the third and the twelfth year after the chancre. Like other tertiary lesions it may be late, and a number of examples have been reported between the tenth and twentieth year; this retarded appearance, according to Mauriac, is even the rule for the aortic localisations. But it is not less certain that arteritis, and in particular that of the encephalon, often appears in a precocious form in the course of the second and even of the first year, coinciding with the cutaneous and mucous membrane eruptions in the full secondary period. Arterial lesions, secondary in point of time, are not more easily curable, nor do they tend to resolve more than the late; anatomically they present the usual characters. There is no justification for classing them apart as secondary arteritis; in fact, a more typical example could not be chosen than that of the arterial lesions to demonstrate that the determination into secondary and tertiary is arbitrary, and only of didactic value. Arteritis occurs as one of the

* *De l'Artérite Syphilitique.* By J. DARIER. Paris: J. Rueff, 1904.

manifestations of hereditary syphilis, but without having distinctive characteristics. Aneurysms of syphilitic origin occur most frequently between the fifth and tenth years after infection, but frequently also from the fifteenth to the twenty-fifth year. If it is not always possible to declare on pathological grounds that an aneurysm is syphilitic, and if specific treatment is often inactive, it is none the less true that the process of syphilis of the arteries is eminently fitted to prepare the vessels for aneurysmal dilatation, and it would be surprising if it did not produce it.

In discussing the histology of syphilitic arteritis the author recognises three types: (1) Endarteritis of Heubner, in which the internal coat of the artery is exclusively or predominantly affected; (2) Periarteritis of Baumgarten and gummatous arteritis, in which the lesions of the adventitia preponderate over those of the internal coat, consisting of an abundant cellular, diffuse, nodular or perivascular infiltration surrounding the vasa-vasorum; (3) Panarteritis, in which all the tunics of the arterial wall are inflamed and altered, and which may be acute—with a diffuse and acute embryonic or lymphatic infiltration, or undergo a fibrous change with more or less complete disappearance of the elements of the middle coat.

Syphilitic arteritis has to be distinguished from two forms of tuberculous arteritis, that which occurs in acute miliary phthisis and tuberculous meningitis of the infantile form, and the tuberculo-caseous type which attacks the arteries comprised in a tuberculous focus, in a plaque of caseous meningitis or bordering on a pulmonary cavity. Infectious, toxic, or dyscrasic arteritis is said not to have a predilection for the cerebral arteries; but prefers the aorta, great trunks and visceral and peripheral arteries. The greatest difficulty in anatomical diagnosis occurs in connection with atheroma; in this the lesions are more diffuse, may vary more in intensity, affect the whole system, include the finest ramifications on or penetrating the encephalon, predominate at the bends or angles of bifurcation, and do not extend to the meninges. Atheroma is also attended by a marked tendency to fatty or calcareous infiltrations. The author expresses the opinion that syphilis may be correctly counted among the causes of atheroma, and quotes a case of Cornil's in support of this view.

In considering the symptoms of syphilitic arteritis, the author restricts himself to those which are indirect or due to embolism, and for the direct symptoms, due to the lesion of the artery itself, refers the reader to the classical works on the subject. An interesting account is given of the symptoms of peripheral arteritis of the obliterative type, which include paræsthesiæ, intermittent-claudication, and various nutritive disturbances, such as permanent coldness or cyanosis of the extremities, œdema, anæsthesia to temperature and touch, anæsthesia dolorosa, etc., and finally gangrene. Proust has reported a case which showed alteration of the nails and glossy skin, and a certain number of cases exist in the literature in which syphilitic arteritis has been supposed to be the cause of excavating ulcers and mutilating syphilides of the extremities, fingers and toes, lesions which others refer to tertiary phagedænic ulceration.

In the chapter on diagnosis special stress is laid on the value of lumbar puncture and the eye symptoms. The leucocytosis in the former is not pathognomonic, the Argyll Robertson phenomenon also occurs in other circumstances, but the abolition of the light reflex with or without preservation of the accommo-

dation reflex, and with or without myosis, is in itself a stigma of syphilis of the nervous centres; it may be absent, but when it occurs it is pathognomonic.

As regards prognosis, in the case of *cerebral arteritis*, mercury and iodide can widen the calibre of a contracted artery but cannot re-establish the circulation in an obliterated trunk, nor restore the functions to the parts of the brain which have undergone necrobiosis. The chances of healing vary then according to the time of therapeutic intervention, the prognosis depending on the age of the lesions, their degree and extent, and on the presence or absence of any special symptoms; it also depends on their variety, gummatous periarteritis being relatively more curable than obliterative endarteritis.

For *aortitis* the conditions are scarcely more favourable; a temporary anelioration and retardation of evolution is all that can be expected from treatment.

Peripheral arteritis, taken at the period in which it is only marked by pain and functional troubles produced by effort, is curable. The extreme tendency to relapse and to recurrences must, however, be taken into account.

For months and years, perhaps through all the course of the patient's life, he is exposed to the repetition of accidents in the arterial territory which has been affected. In cerebral arteritis, for example, it is almost the rule that the subject who has recovered several times, ends by succumbing to a last attack of the same kind. Another point which the author thinks should be borne in mind is the occurrence of a possible transformation of syphilitic arteritis into arteriosclerosis or atheroma, or at least the occurrence of atheroma in syphilis.

The *treatment* of syphilitic arteritis should be immediate and energetic. Mercury should be given by injections in the form of a good dose of calomel, 10 c.gr. for an adult man, 5 to 7 c.gr. for a woman or adolescent, injected into the buttocks, to be renewed every five to eight days. Soluble injections of biniodide, benzoate, or cyanide of mercury in aqueous solution in doses of 2 to 4 c.gr. a day are as good or nearly so, and preferable in the case of a bad state of the mouth. The writer has had satisfactory results from intravenous injection, but does not claim superiority for it. Injections into the subarachnoid space are spoken of with reserve, pending further experiments on animals. Arterial syphilis constitutes an indication of the first order for the exhibition of iodide of potassium. It should be given in large doses, generally of 8 to 12 grms. in an urgent case; a dose of 2 to 4 grms. given for a long time is very useful in syphilis of the aorta or visceral and peripheral arteries. The duration of treatment depends upon circumstances. Four to five weeks of active mixed treatment is a minimum in serious cases. Then if there is amelioration, two or three weeks of rest may be given and the medication resumed and continued for months and often years.

After referring to some accessory methods of treatment such as lumbar puncture and various hygienic measures, the author concludes with the advice that every syphilitic infection should be treated energetically and for a long time.

S. E. D.

A PRACTICAL TREATISE ON GENITO-URINARY AND VENEREAL DISEASES AND SYPHILIS.*

THE third edition of Taylor's *Treatise on Genito-Urinary Diseases and Syphilis*

* *A Practical Treatise on Genito-Urinary and Venereal Diseases and Syphilis.* By ROBERT W. TAYLOR, A.M., M.D. Third Edition. London: Henry Kimpton, 1905. Price 28s. net.

brings this useful text-book again up-to-date. In it the text has been fully revised and various new sections have been added. The portion of the volume which is of special interest to the readers of this Journal is the 250 pages which deal with syphilis; and the description of the disease given in those pages is most readable, concise, and practical. In Chapter XXIV the writer describes the nature, course, and prognosis of syphilis. He assumes the presence of an unknown micro-organism as the cause of the disease, and considers that the potency of the virus is much the same whether it be inoculated from the initial lesion, secondary lesions, or the blood, and that the severity of the attack is determined by the condition of the individual. His experience corresponds with that of most observers that the severity of the disease is steadily diminishing, partly from better sanitation and improved methods of treatment, and partly from a greater resistance on the part of the individual attacked caused by a moderate degree of immunity due to changes in the tissues and in the blood induced by syphilis in more or less remote ancestors. Thirty years' experience of the disease, its varieties, course and treatment, has convinced the author that in the majority of cases syphilis is a curable affection, provided the treatment be sufficiently vigorous and intelligent. In discussing the changes in the blood in syphilis with regard to the Justus hamoglobin test it is interesting to note that the author found from a study of all his cases where the test had been properly applied that the test gave a positive result in from 70 to 80 per cent. of all doubtful ones. On page 486 the writer reports an authentic case of re-infection with syphilis in which the patient, a woman, was first infected at the age of 27 years, and had a severe attack of the disease which was followed in due course by characteristic scar-leaving serpiginous lesions. Eleven years after the initial attack she was re-infected and a corymbose syphilide developed over the skin. The case is illustrated by a coloured plate showing the presence of the corymbose syphilide resulting from the second infection and the scars and tertiary lesions which remained from the primary attack. The writer has had four other cases of re-infection under his care.

In discussing the treatment by hypodermic injections, the writer gives his preference to the soluble salts and especially the perchloride of mercury, employing it in doses of $\frac{1}{4}$ of a grain every second day.

The subject of hereditary syphilis is also fully discussed. The text-book is well illustrated throughout, both by coloured and black and white plates. Several of the coloured plates are crude and might be improved, but the black and white illustrations are excellent.

THE BRITISH JOURNAL OF DERMATOLOGY.

NOVEMBER, 1905.

A CONTRIBUTION TO THE STUDY OF URTICARIA PIGMENTOSA.

By E. GRAHAM LITTLE, B.A., M.D., M.R.C.P.,

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Hospital for Children, Shadwell.*

(Continued from page 373.)

OBSERVATION 9. (EAST LONDON HOSPITAL FOR CHILDREN.)

George W—, aged 5 years. The parents are Hanoverians. (This case is not related to Edward W—, Obs. 8). There are thirteen children in the family, but all the others are quite free of the disease; there is no urticarial or "nervous" history in either of the parents. The mother states that her pregnancy which resulted in this child was normal throughout, but that she had had a bad miscarriage seven months before the time of quickening with this child.

Onset of the eruption.—The child was first washed by the mother fourteen days after birth, and it was then that she noted its presence. It was probably not present at the actual time of birth, as the doctor who had delivered the mother was called in when the eruption was noticed by the mother, and he had not noted it previously. Itching was entirely absent, and has never been a conspicuous feature. The eruption appeared at first upon the lower part of the body, and for some time after the first outbreak new "spots" came out from time to time, but these have ceased to appear within recent years.

Character and distribution of the eruption (Fig. 13).—This consists entirely of macules, which are not raised at all from the surface of the skin, so that it is impossible to distinguish their presence by the aid of touch alone. The lesions are round or oval, from about one eighth to a quarter of an inch across, and there is no coalescence into larger patches of united smaller macules. The colour is a dusky, reddish-brown, the reddish tint being present even in the unirritated patches. The distri-

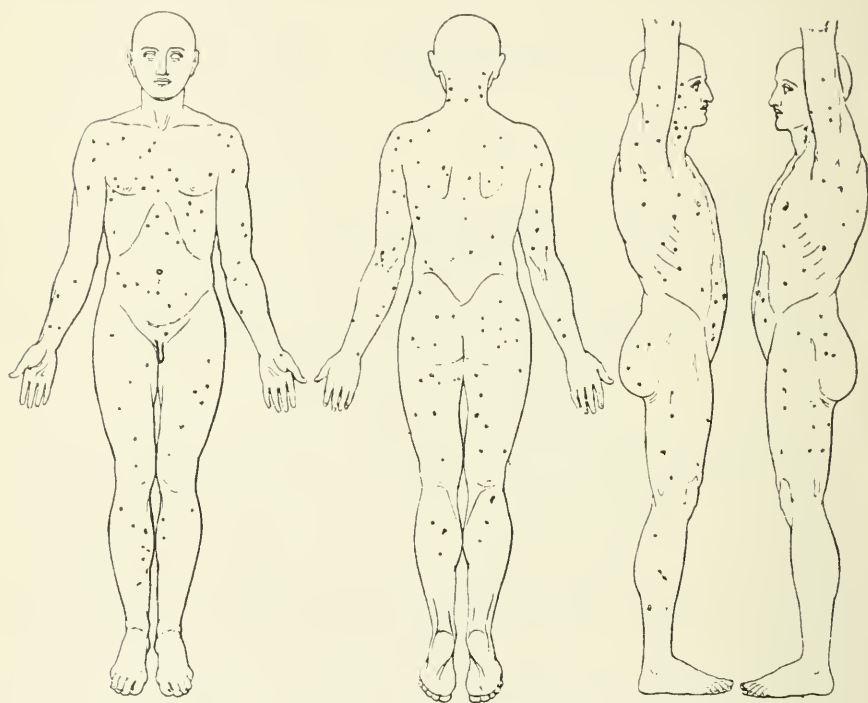


FIG. 13.

bution is sparser than in many of the cases, the spots being divided by large tracts of apparently healthy skin, and there is no grouping. It is difficult to say that the rash is anywhere especially thick. Scattered macules are found upon the chest, abdomen, sides of the trunk, thighs, legs, arms, and forearms. There are a few upon each cheek, but not on the forehead or front of the face, and the palms and soles are clear with the exception of a single lesion at the base of the thenar eminence on the left side. There are no spots on the buccal mucous membrane.

There has been no itching at any time, but there is fairly definite factitious urticaria on scratching the healthy skin; and the lesions become red and swollen when they are irritated. The general health is quite satisfactory, with the exception of, at the present time, a certain degree of weakness due to the after-effects of an operation for adenoids. The colour of the eyes is blue, the hair brownish-yellow. There is a small, deeply-pigmented mole, about one eighth of an inch across, upon the chest. The glands in the posterior and anterior triangles of the neck, and in the axillæ and groin are all markedly enlarged.

HISTOLOGY.

George W— (Fig. 14). Specimen of skin taken from the arm. The epi-

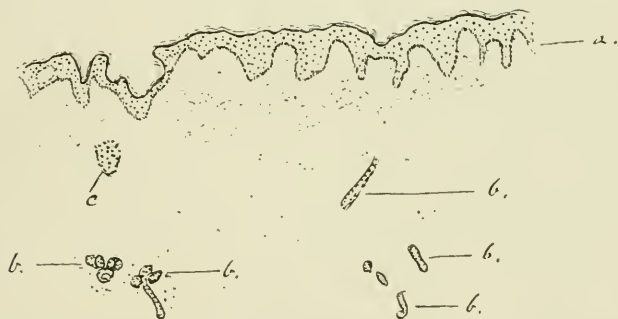


FIG. 14.—Stained with polychrome methylene blue + alum. Drawn with camera lucida ($\times 70$). *a*, Basal layer of epidermis, with pigment-cells; *b*, sweat-glands with mast-cells near; *c*, portion of hair-shaft with mast-cells near. The infiltration of the corium, figured above, is composed of mast-cells.

dermis appears thinned in places; there is considerable intra-cellular œdema. The granular layer is normal.

Pigment-cells.—These are several layers in thickness, and there are a great many pigment-cells in the corium. The pigment is more abundant than in any case, except those of Lilian C— and Hettie C—; the granules are very numerous, and stain a rich golden colour with polychrome blue.

Mast-cells.—These are confined to the interpapillary zone and the upper part of the corium; they are more diffused, however, than in the other cases where the arrangement is superficial, and do not seem confined to or even especially abundant, in the neighbourhood of the blood-vessels. There are a few scattered cells in the deeper zones of the corium, especially about the coil-glands. The mast-cells are well formed, but there is also a considerable amount of granular debris.

Elastin and collagen.—The elastin is disorganised and fragmented, especially in the superficial zone of the corium; the collagen is less altered, but shows some rarefaction. The blood-vessels are dilated in the superficial zones of the corium.

and there is considerable extravasation of corpuscles from them in several sections.

OBSERVATION 10. (EAST LONDON HOSPITAL FOR CHILDREN.)

(Sent to me by the kindness of my colleague, Dr. Morley Fletcher.)

Reggie F—, aged 11 years. English parentage. There are four other children living, all of whom are quite healthy as regards the skin. Two children are dead, one at three months after birth, from "pnenmonia," this child had further a general eruption on his body for one month before his death; no particulars that could be estimated with any accuracy were obtainable as to the type of eruption. The other child who died was born prematurely, at six months. An elder brother, who is now in good health, with no disease of the skin, had, a few days after birth, an eruption of "blisters" which became yellow (suppurating?) and formed open sores; these persisted until about the age of six months. No permanent marks resulted from these lesions, which the mother did not regard as being at all similar. The mother is a highly neurotic woman, with a family and personal history of epilepsy; she has had frequent fits herself, and two (maternal) cousins died imbeciles as the result of "fits." None of the children of these parents, however, seem to have had fits up to the present time. Several of the children, including the present case, had jaundice at birth, the yellow colour persisting for about a month. The mother appears to have been ill for a part of the duration of her pregnancy with this child, and was under medical treatment, the nature of which is unascertainable.

Onset of the eruption.—The earliest age at which anything abnormal was noted as regards the skin was at six months, when quite suddenly a general invasion of the upper part of the body by brown spots became apparent. The child was feverish and ill at the same time, but there was no itching; the skin appeared to be smarting, however, and even painful. As he became older and had fresh outbreaks, he was able to describe the sensation felt with the outbreak as "like pins and needles all over him." The lesions were pinkish, turning to brown, and could be felt as small lumps "like peas under the skin." During the period from 6 to 10 months of age he had fresh outbreaks of the same type, ushered in by feverish attacks, but with no symptoms of itching. Then followed an interval of freedom from fresh attacks

which lasted for two and a half years. At the end of this time he was the subject of a fresh outcrop of spots, the older lesions persisting as pigmented stains. Five years ago, when I first saw him, he had had a fresh attack supervening upon measles (which had not appreciably altered the aspect of his macular eruption). Finally, two years ago, he had again a severe fresh outbreak with feverishness and constitutional disturbance.

Character and distribution of the eruption (Fig. 15).—This is chiefly

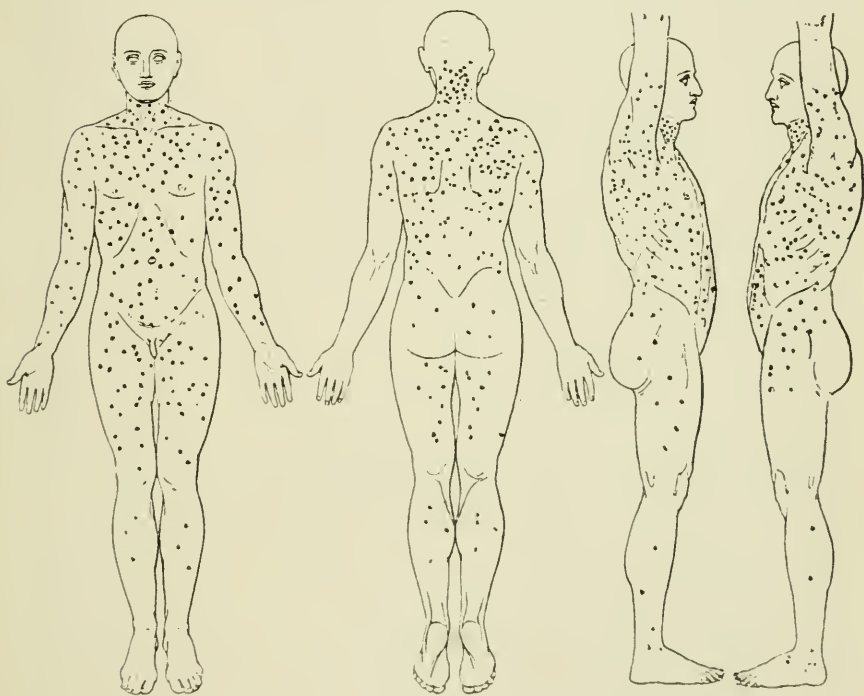


FIG. 15.

concentrated upon the trunk and shoulders, which are very thickly covered by a macular eruption without any salient lesion; the neck is very nearly entirely obscured by the stains; they are a little less numerous, but still very closely set on the chest, over the prominence of the deltoid muscles, on the sides of the body from the axillæ to the hips, on the back of the neck up into the hair, over the shoulders, and especially over the scapulæ; the eruption ceases to be closely grouped at the level of the pubes, and on the thighs and legs there are only a

few disseminated stains which are fainter in colour than those above the pubes; the buttocks are almost free, and there are no lesions on the backs of the arms below the level of the insertion of the deltoids, but on the front of the arms and forearms there are rather numerous macules nearly to the level of the wrist. The face at the present time is quite free, but the mother thinks that lesions have been present here and have disappeared. The palms and soles remain entirely unaffected, and the buccal mucosa is normal.

The lesions are of the colour of milky coffee, and are uniformly small, not exceeding a quarter of an inch in their largest diameter, and more often about one eighth of an inch across. They are chiefly circular or oval, but on the neck particularly they are oblong, with the long axis of the lesion in the transverse diameter of the neck. There is still quite active response of even the faintest macules to scratching; they become red and swollen, and there is also very definite factitious urticaria of the unaffected areas of the skin. But spontaneous itching is almost completely absent. There has not, however, been any noticeable regression of the lesions during the period he has been under my own observation (five years).

It has been mentioned that the boy had jaundice at birth which lasted a month. He has always, according to the mother, been a "bilious boy," but has never had jaundice again. His skin, except in the affected parts, is of normal whiteness, and his colouring is fair; he has very light brown almost grey eyes, and yellow-brown hair. His "biliousness" seems to consist in a liability to be easily "upset" by rich food. He has frequent headaches, but has never had fits. His weight is 5 st. 7 lb., and he appears a normally developed boy for his age. His mother's description of the earlier appearance of the eruption as being like peas under the skin is suggestive of the presence at that time of a nodular or mixed type of eruption; but throughout my own observation of the boy the eruption has been restricted to the macular type.

HISTOLOGY.

Reggie F— (Fig. 16). Specimen of skin taken from back. The epidermis is thrown into folds and ridges, the swelling of which appears to be caused by masses of cells immediately below the epidermis, these masses corresponding to the elevations and consisting of mast-cells. The epidermis appears slightly thinned over these masses of cells. The granular layer is deficient, in places absent. The epidermal cells in many places are vacuolated (*altération cavitaire*).

Pigment-cells are seen in the basal layer, and in the two or three superposed layers of the epidermis; they are also found in isolated numbers in the corium, usually amongst the masses of mast-cells or near these masses. The pigment-cells in the epidermis are columnar in shape with the long axis vertical to the surface of the skin. The pigment-granules are a yellowish-green (stained with polychrome blue and alum) and form a copious envelope round the nucleus (stained light blue); the pigment-cells in the corium are fusiform and cuboidal in shape.

Mast-cells.—These occur in massed accumulations in the interpapillary zone of the corium; they are separated from the epidermis by a narrow space in which the connective tissue appears thinned. Besides these massed accumulations numerous mast-cells are seen along the blood-vessels both in the superficial and deeper parts of the corium; the cells both outline and occupy the blood-vessels, so that mast-cells are seen lying among the corpuscles which fill the vessels, as

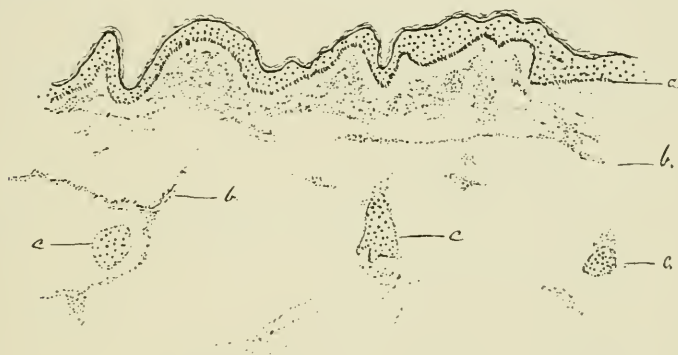


FIG. 16.—Stained with polychrome methylene blue + alum. Drawn with camera lucida ($\times 70$). *a*, Basal layer of epidermis, with pigment-cells; *b*, dilated blood-vessels, outlined by mast-cells; *c*, portion of hair-shaft with mast-cells near. The infiltration of the corium, figured above, is composed of mast-cells.

well as outside and along their channels. The vessels appear enlarged and more numerous, or, at any rate, more distinct, than in normal skin; the mast-cells are well formed in spite of their close grouping. They are found in small numbers about the hair-follicles and sweat-glands, but not distributed generally in the corium below the level of the massed accumulations in the interpapillary zone.

Elastin.—In specimens stained with Weigert's solution only there are obvious lacunæ in the elastin framework; these lacunæ are seen in specimens stained with Weigert + hæmalum + v. Gieson stains, to correspond with the masses of mast-cells which there appear to crowd out both the elastin and collagen-bundles.

OBSERVATION 11. (EAST LONDON HOSPITAL FOR CHILDREN.)

Emily F—, aged 9 years, of English parentage. (Not related to Reggie F—, Case 10.) There have been two other children in the family, neither of whom had any skin-disease; one child died in infancy. The parents are quite free of any urticarial symptoms, and have no skin-disease.

Onset of eruption.—The first lesion was noted, at the age of 3 months, as a small yellow flat patch on the back (over the spine of the sixth dorsal vertebra). This persisted as a unique patch until she was 5 years of age, when a second similar single patch developed on the skin over the lower angle of the scapula on the left side. The patches were itchy at first, but itchiness has ceased now. No fresh lesions ever appeared, and these two remained unchanged until she came under my observation three years ago, when the smaller and more recent lesion (over the angle of the scapula) was excised by me; from this specimen of the skin the section figured below (Fig. 17) was made. The other and sole remaining lesion has now been excised at the mother's request.

The lesions were strictly flat, but reddened readily on being irritated and became slightly swollen. They were a light lemon-yellow colour when unirritated; the older lesion was about half an inch wide and three quarters of an inch long, the long axis being vertical. The second, more recent, patch was slightly smaller and nearly round.

There is no general itching of the body, but factitious urticaria is an easily demonstrable phenomenon.

Enlarged glands are just perceptible in the axillæ, anterior and posterior triangles of the neck, and the groin.

The child is said to be "bilious"; she suffers frequently from sick-headaches, but she has never had jaundice. She has yellow hair and blue eyes, and has a fair skin; there is a line of light-brown pigmentation about one eighth of an inch wide, extending from the umbilicus to the pubes; with this exception there are no other pigmented spots upon the body, and there are no lesions on the buccal mucous membrane.

HISTOLOGY.

Emily F— (Fig. 17). The section of the skin was taken from the back from a lesion about twelve months old. The surface of the epidermis is broken up into numerous minute papules, the (microscopic) eminences corresponding to infiltration of the interpapillary zone and pars reticularis of the corium with crowded cells (mast-cells), which stain a purplish red with polychrome methylene blue + alum. The stratum corneum is slightly thickened, and is easily detached, as is seen in the section figured. There is slight thinning of the epidermis in places, apparently over the masses of mast-cells. The granular layer is deficient or altogether absent. There is a certain amount of vacuolation of the epidermal cells (*altération cavitaire* of French authors).

Pigment-cells.—The pigment is contained in large columnar cells of the basal

layer of the epidermis. These cells consist of a pale blue nucleus, surrounded by a granular envelope, the granules staining a yellowish-green with polychrome blue. These pigment-cells are not evenly distributed in the section; in some parts the cells are several layers in thickness, in others they occur only in the basal layer. The pigment-cells are seen to be present beyond the margin of the diseased skin (as represented by the underlying massed mast-cells). Very occasionally pigment-cells are seen in the corium; in this position these cells consist of a pale blue nucleus with a fusiform envelope of greenish-yellow granules; this cell is shaped therefore very like the mast-cell, but the granules are of a different colour: the sporadic pigment-cells are found in the vicinity of the mast-cells, and usually just under the basal layer of the epidermis.

Mast-cells.—These are found in the interpapillary layer and *pars reticularis*; except for a narrow space immediately below the epidermis, which is free of mast-cells, and where the connective tissue is thinned, the mast-cells are found throughout the corium down to the level of the sweat-glands. They are arranged in long rows parallel to the surface of the skin, and these rows in some places at least are obviously along the course of vessels. The vessels are dilated and very numerous. The mast-cells surround and penetrate the vessels, so that

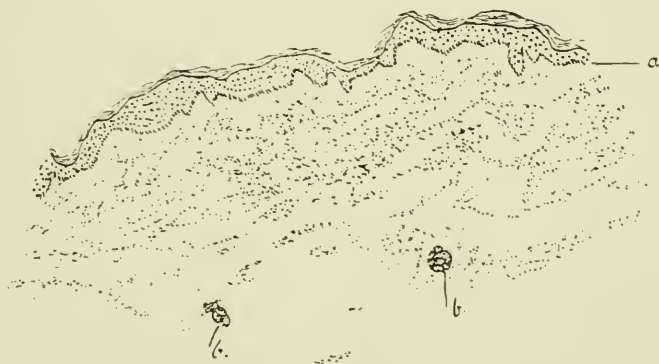


FIG. 17.—Stained with polychrome methylene blue + alum. Drawn with camera lucida ($\times 70$). *a*, Basal layer of epidermis, with pigment-cells; *b*, sweat-glands, with mast-cells near. The infiltration of the corium, figured above, consists of mast-cells.

they are seen mingling with the contents of the vessels. There is much granular *debris* present, the granules staining like the granules of the mast-cells, and obviously formed by breaking up of these cells, but many cells are visible with well-formed nucleus and fusiform envelopes—typical mast-cells. There are sporadic mast-cells around the coil-ducts.

Elastin.—This is copiously present throughout the section, and appears normal in character, not broken up or thickened, but the massed cells have crowded back the elastin, which thus, as it were, encapsules them. Occasionally, especially in the superficial layers, the elastin fibres penetrate the masses of mast-cells, running up into the epidermis between the epithelial cells of the basal layer.

The histological appearances in this case offer an intermediate stage between the strictly superficial infiltration of the cases of Thomas M—, Reggie F—, and Alfred P—, and the generally-disseminated cells of the tumour-cases (Edward

W— and Cecil B—). But the arrangement around vessels is still fairly obvious in this case, whereas in the two latter this arrangement is no longer appreciable.

Examination of the second specimen, obtained from the lesion which had been noted from the age of 3 months to the present time—a period of nine years (Fig. 18), whereas the first examination, above recorded, was made from a lesion which had lasted only a few months at the date of excision. Both lesions had been near each other, upon the back of the patient.

The *epidermis* is thin. The keratohyalin is normal. There is no intra-cellular oedema.

Pigment-cells.—These are very irregularly distributed, being almost absent in some parts of the rete, and fairly abundant in other parts, but nowhere to the same degree as in the earlier section figured above. There are numerous pigment-cells free in the corium. The pigment-granules are scanty, and light in colour.

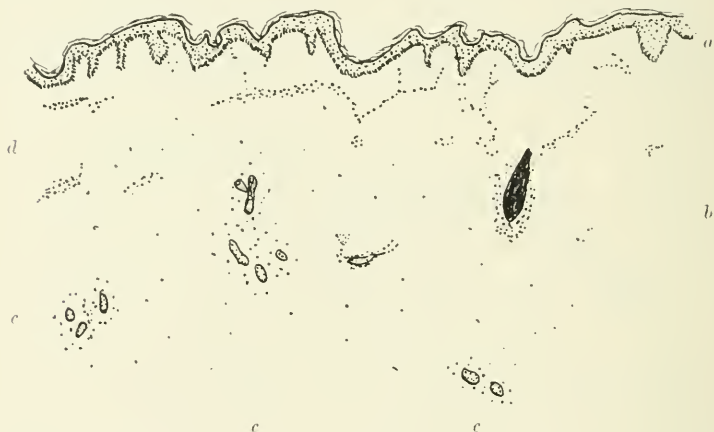


FIG. 18.—Stained with polychrome methylene blue + alum. Drawn with camera lucida ($\times 70$). *a*, Basal layer of epidermis with irregularly disposed pigment-cells; *b*, portion of hair-shaft, surrounded by mast-cells; *c*, sweat-glands, surrounded by mast-cells; *d*, enlarged blood-vessel, outlined by mast-cells.

Mast-cells.—These are found chiefly about the hair-shaft and sweat-glands. The blood-vessels in the sub-papillary plexus are also accompanied by moderate infiltration of mast-cells, but not nearly to the same extent as in the earlier section. There are a very few free mast-cells scattered through the section, chiefly in the deeper part of the corium. The blood-vessels are still perceptibly enlarged.

Elastin and collagen.—These are little, if at all, altered.

OBSERVATION 12. (ST. MARY'S HOSPITAL.)

Hettie C—, aged 3 years, of English parentage. (Not related to Lilian C—, Observ. 2.) The mother has had five children in all, of whom four are living. There is no parental history of interest and

this is the only person in the family who has any skin-disease. The mother had a normal pregnancy with this child and took no medicine during the gestation.

Onset of the eruption.—This was first noted about three months after birth, but it may have been present earlier, as the mother gave the following history. The child was “born nearly black” and this dark colour only slowly wore off, in about two to three months after birth; it was then noted that “spots” of deep, almost scarlet, red colour were present. The meaning of the colouration at birth is impossible to ascertain; from the history it would appear to have been due to “*icterus neonatorum*.” The amniotic fluid was, indeed, voided somewhat early in labour, but this was not protracted or especially difficult, and lasted only $2\frac{1}{2}$ hours. The eruption was present at 3 months in the positions where it now is. There has been no fresh invasion, and the colour of the spots is said to be fading perceptibly. These have been flat throughout their existence, and itching is and always has been completely absent. The eruption is composed of dusky brownish-red macules, quite flat, and varying in size within narrow limits; they are mostly from a half to a quarter of an inch in their longest diameter, and are oblong and oval. On the chest and trunk the long diameter is usually in the girdle axis of the body. On the lower limbs the lesions are distinctly redder and larger than on the trunk. The macules are all discrete; they become turgid and deeper in colour when scratched, and there is pronounced factitious urticaria of the apparently healthy skin.

Distribution of the eruption (Fig. 19).—This is not as copious as in many of the cases, and is curiously asymmetrical, as will be noted from the diagram-figure showing the distribution. There are several spots on the face and neck, but not apparently on the scalp. There is a band of patches running across the chest and upper arms at the level of the nipples; a closely-set group of patches on the left side of the abdomen, the right side being quite free; on the other hand, the right thigh is much more thickly covered than the left thigh, but the left leg is more affected than the right leg. The right side of the trunk from the axilla to the hip is quite free from lesions, while the corresponding part of the body on the left side shows numerous patches; the left buttock is much more extensively covered than the right buttock. Both forearms are on their anterior surfaces quite clear of eruption.

but are nearly equally affected upon their posterior surfaces down to the wrist. The palms and soles and buccal mucous membranes are quite unaffected.

The glands in the posterior triangles of the neck are greatly enlarged; the condition is comparable to the glandular enlargement of secondary syphilis; they are less but still undoubtedly enlarged in the anterior triangles of the neck and in the axillæ and groins.

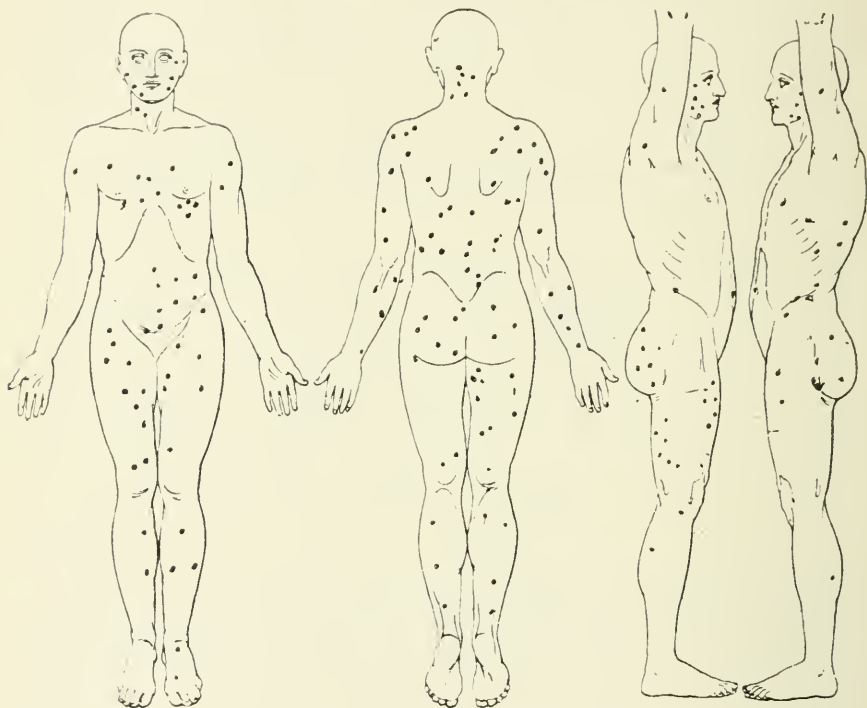


FIG. 19.

The child looks somewhat "pasty," but is said to be in good general health, and has no intestinal troubles and does not suffer from headaches or "biliousness." She has blue eyes and light yellow hair, and there are no anomalies of pigmentation other than the lesions of the disease as described.

HISTOLOGY.

Hettie C— (Fig. 20). The specimen was taken from the back. There is slight parakeratosis. The epidermis is thinner over the collections of mast-cells

than elsewhere. The stratum granulosum is not deficient in this case, and there is no marked epithelial oedema.

The *pigment* is most irregularly distributed: in places it is found in several layers of the rete beyond the basal layer—five or six rows deep; in other parts of the section it is confined to the basal layer. The pigment-granules are exceptionally dark in colour—almost black in parts, and there is abundant pigment, and there are also many free pigment-cells in the corium. This case shows probably the darkest and most copious amount of pigment found in the series of cases here recorded—an unexpected result, as the lesions clinically were rather strikingly pinkish, as well as brown, and the latter tint was a light shade of that colour.

The *mast-cells* are numerous but obviously grouped, not disseminated: the grouping is principally around the blood-vessels (which are appreciably enlarged and abnormally numerous), the hair-shaft, and the sweat-glands. The mast-



FIG. 20.—Section stained with polychrome methylene blue + alum. Drawn with camera lucida ($\times 70$). *a*, Basal layer of epidermis, with pigment-cells; *b*, portions of hair-shaft, surrounded by mast-cells; *c*, sweat-glands, surrounded by mast-cells. The infiltration of the corium, as figured, is composed of mast-cells.

cells are well formed throughout with normal nuclei and with granular envelopes.

Elastin is very deficient throughout the part of the corium in which mast-cells are seen. The rarefaction of the collagen-bundles is less obvious than in the other cases recorded, but the sections were, accidentally, probably somewhat thicker in cutting.

OBSERVATION 13. (ST. MARY'S HOSPITAL.)

Isabella G—, aged 37 years, of English parentage. She has had six children and no miscarriages; the children have no skin complaints. Her last child was born seven years ago, and she has not been pregnant since that date.

Onset of eruption.—The changes in the skin were noted four years ago for the first time, and consisted then of an eruption of “dark spots,” which spread to form large areas of pigmentation of a mottled

appearance. The face became dark, but with a uniform pigmentation, without mottling. The brown patches were slightly itchy at the earlier stages of their appearance, but no direct history of wheals could be obtained. The brown circumscribed patches, as distinguished from the large sheets of pigmentation, became reddened and slightly turgid upon being irritated. There is also well-marked factitious urticaria ("dermographism").

Dr. G. B. Currie, of Ealing, who has watched the case for some

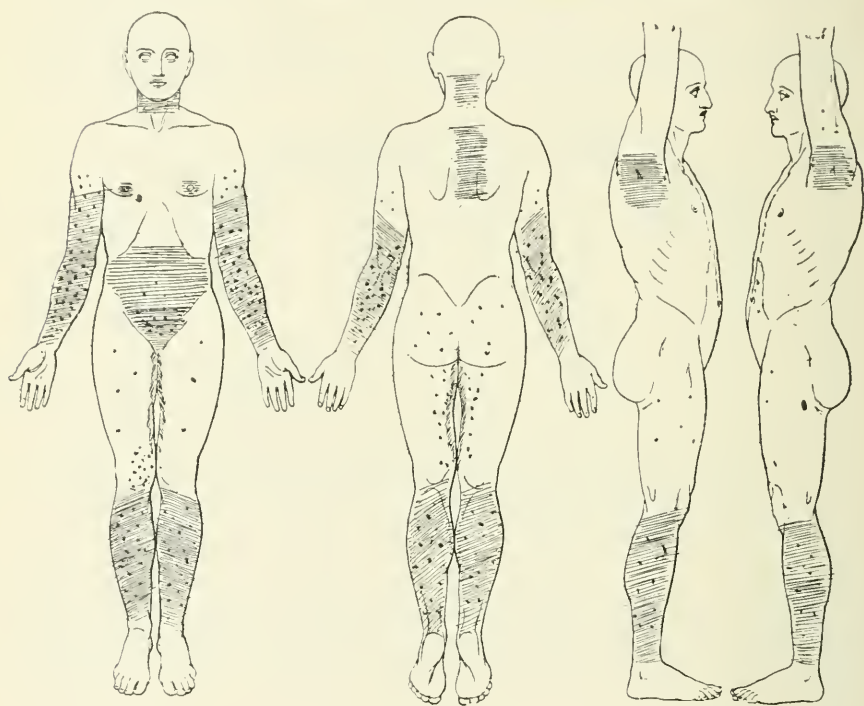


FIG. 21.

years, and to whom I am indebted for the opportunity of seeing the patient, writes regarding its onset: "I am satisfied the pigmentation is unassociated with pregnancy; there was no sign of it when she was last confined, seven years ago. The pigmentation, in fact, commenced four years ago, apparently beginning around the anus."

Character and distribution of the eruption (Fig. 21).—The changes at present to be noted in the skin are of two kinds—large areas of fairly uniform pigmentation of a deep, walnut-brown tint, and

upon these areas darker circumscribed macules, giving the affected parts a mottled-brown appearance; the darker stains are also seen beyond the margin of the large sheets of pigmentation, but usually near these. The parts thus pigmented are as follows: the neck, especially in front; the arms from the level of the insertion of the deltoid to the wrist; above the pigmented area there are some isolated small macules (one of which was examined, and the result is reported below); the abdomen below the level of the umbilicus; the mid-vertebral space between the scapulæ; the inner sides of the thighs; the axillæ; below the level of the knees there is a pinkish-brown pigmentation with some circumscribed patches of deeper brown; there are some light brown, indefinite, ill-demarcated stains upon the buttocks and the thighs. The nipples are deeply pigmented. The face is a general sallow brown colour, without the appearance of mottling present on the body as above described. There is no prominence above the general level of the skin of any of the macules, but wheals seem somewhat especially easily produced upon the legs. There is no pigmentation of the buccal mucous membrane; there is marked pigmentation surrounding the anal orifice, and this appears to have been the earliest position in which the uniform, as distinguished from the patchy, pigmentation was noted. The case was seen at my request by one of my colleagues, a physician to St. Mary's Hospital, and his note is to the effect that "there are no other symptoms of Morbus Addisonii beyond the pigmentation." Itching is never very noticeable, but the pigmented portion of the skin, especially on the legs, seems occasionally to be moderately itchy.

There is no enlargement of glands.

The patient is normally a fair woman, with grey eyes, and light brown hair. She has never had jaundice. There is no obvious wasting or constitutional disease of any kind.

A very similar case was reported by Rona, in which mast-cells were also sparsely present in the sections examined. In this case symptoms had likewise commenced in adult life. (*Abst., Brit. Journ. Derm.*, 1897, p. 460).

HISTOLOGY.

Isabella G— (Fig. 22). Specimen of skin taken from front of upper arm.

The epidermis is thin and rugose. The keratohyalin layer is not deficient. There is considerable intra-cellular oedema.

The *pigment-cells* are very rich in granules, which are a dark greenish-yellow colour; the cells are found in two or three layers of the rete above the basal layer as well as in that layer itself, and there are also numerous free pigment-cells in the corium.

The *mast-cells* are extremely scanty when compared with the rest of the cases here recorded; but the arrangement of the cells is the same, namely in the course of the blood-vessels and around the sweat-glands and the hair-shaft. These cells, although scanty in comparison with the state of affairs in the greater number of the cases of *Urticaria pigmentosa* here recorded, are far more numerous

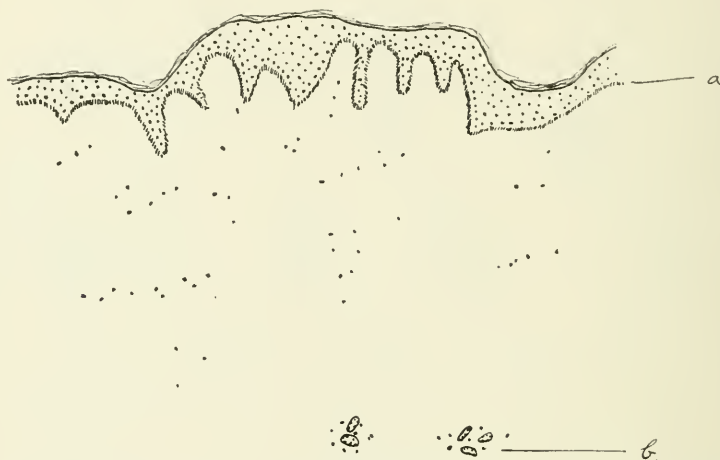


FIG. 22.—Section stained with polychrome methylene blue + alum. Drawn with camera lucida ($\times 125$). *a*, Basal layer of epidermis, with pigment-cells; *b*, sweat-glands, with mast-cells near. (The glands are drawn disproportionately small.) There is a scanty sporadic infiltration of the corium with mast-cells, which are found around the blood-vessels.

than is the rule in normal skin or in the case of any other affection except *Urticaria pigmentosa*. The cells are quite well formed with typical granules and nuclei.

The *elastin* and *collagen* are but little disturbed when compared with the other sections here described; but there are some lacunæ, occupying the position of the mast-cells where these are found, in the general feltwork of the elastin.

It will thus be seen that the histology, while not absolutely typical of the disease, is on the whole confirmatory of the diagnosis of *Urticaria pigmentosa*.

OBSERVATION 14. (EAST LONDON HOSPITAL FOR CHILDREN.)

(Sent to me by the courtesy of my colleague, Mr. H. Betham Robinson).

Herbert M—, aged 11 years, of English parentage (not related to Thomas M—, Case 5). The mother has had seven children; all the others remain free of any skin-disease; this is the third child in point of age. There is no family history of importance; the mother appears a somewhat neurotic woman. She had one miscarriage at three months, about fourteen years ago. She took no drugs during the pregnancy with this child. A very clear history was obtained to the effect that at the time of the birth of the child the grandmother, who acted as midwife, noted the presence upon the body of the newly-born infant of three "red" marks with white centres—one on the leg, one on the abdomen, and one on the breast. These persisted, and others, similar to these, appeared elsewhere on the body when the child reached 2 to 3 months of age; the marks did not go away and he was consequently, when 6 months old, brought to the hospital and seen by Mr. H. Betham Robinson. The lesions, according to the mother's account, were at the time raised above the general level of the skin, were the size of a pea, and of a brownish-red colour. They were quite numerous, new spots coming out from time to time, and leaving stains which did not wholly disappear; the lesions appeared to become simultaneously flattened at about the age of $2\frac{1}{2}$ years, the pigmentation persisting for many years longer.

Mr. H. B. Robinson has most kindly allowed me to make the following extracts regarding this case from his note-book: "Seen April 23rd, 1895. The child was born with two or three pigmented spots, one on the head. Since then pigmented spots have appeared with wheals in the middle. More seem to have come out since vaccination. No apparent variation in spots; those out seem to remain permanently. There is one very marked wheal at the front of the right axilla with pigmented area. April 30th: A few more spots about the body; child not irritable; eruption does not appear to itch, as there is no attempt to scratch. May 14th: More spots, and more "whealy." Cold in head at times; ? snuffles. Pulv. Hyd. \bar{c} creta given. May 28th: A few more spots upon the face. June 25th: Spots about the same; Pulv. Hyd. \bar{c} creta continued. July 23rd: More spots. August 13th: More spots on trunk. August 27th: Pulv. Hyd. \bar{c} creta discontinued, and liquor arsenicalis prescribed; child is cutting his teeth. September 10th: A few spots have appeared on the cheek. October 29th: A few spots on the right

side of the face, but no wheals; some spots on the body seem to have faded. November 12th: Spots now lemon-coloured; no fresh ones. August 17th, 1896: Much about the same as before: new spots on the abdomen, and the old spots are deeper in colour."

"This case was shown at the International Dermatological Congress, held in London in 1896, and is recorded in the *Transactions* of that meeting."

Mr. Robinson has no further notes of the case.

Present condition (September, 1905).—It is obvious that many of the lesions must have entirely disappeared, since the eruption is now scanty, and the foregoing notes explicitly mention lesions in positions which are now quite clear. The mother's statement corroborates this conclusion. The present lesions are of a very pale brownish-yellow, quite flat, roundish and triangular in outline, about a quarter of an inch in diameter, and with the following distribution:

Anterior surface.—Two spots on the right side of the neck; one on the line of the lower ramus of the jaw on the right side; one on the right side of the chest; two in the mid-ventral line, above and below the umbilicus; two on the left side of the abdomen; one on the right thigh; two on the right leg; one on the dorsum of the right foot and on the left foot; two on the anterior surface of the right forearm.

Posterior surface.—Two on the right upper back, near the vertebral column; one over the spine of the right scapula; three in the horizontal mid-line of the back; one on the right buttock; one on the right thigh and calf; one above the left elbow and one below the left elbow; one on the left thigh and the left calf; one in the right axilla; one on the right side of the body in the mid-axillary line; one on the right thigh and on the external aspect of the right leg below the knee; one in the middle of the external surface of the left thigh, and two on the external surface of the left leg, below the knee.

There are no lesions in the mouth. There are no scars. The glands are enlarged to a perceptible degree in the anterior triangles of the neck, in the axillæ, and in the groin. There is marked "dermographism," and the apparently extinct lesions redden quickly upon being scratched, losing the brown tint they normally possess.

The boy enjoys excellent health; he is not bilious and has never had jaundice, but one of his brothers was born with jaundice.

He has light brown hair and blue eyes. There are no other pigmentations of his skin.

Consent to form a biopsy was not obtainable.

HISTOLOGY.

Note upon the histological methods used in this examination.—The sections of the skin were taken as often as was possible from the back of the patient, partly in order to obtain uniformity, and partly because of the convenience of this position in young children. The excised portions of skin were immediately placed in a solution consisting of .75 saline and .6 formalin, and there left for about six hours. They were then transferred usually to 90 per cent. or 95 per cent. alcohol for twenty-four hours, to absolute alcohol for twenty-four hours, to carbon disulphide for twenty-four hours, and then for varying periods, according to size, into carbon disulphide and paraffin in an incubator at 37° C., and passed through ten dishes of melted paraffin, in which substance they were finally imbedded.

[The biopsy was always performed with a scalpel after anæsthetising the skin with a 1 per cent. solution of eucain.]

The sections were cut with a Cambridge rocking microtome and averaged 5 to 10 μ in thickness. The paraffin was dissolved out with xylol and cleared in absolute alcohol.

Staining methods used.—To demonstrate the mast-cells and the pigment, after many experiments, the most satisfactory method was found to be with a solution of polychrome methylene blue to which alum had been added (a pen-knife point covered with alum to a watch-glass of stain). The sections were left in this for from four to twenty-four hours, always being covered by Petri dishes and so being protected from dust during staining. They were then dried and decolorised in absolute alcohol until a distinctly red tone was prevalent in the section, the blue staining of the epidermis being almost too faint to be perceptible. By this method it was found possible to obtain sections in which only the granules of mast-cells and pigment-cells were distinctly visible, the nuclei and other cells than mast-cells being "shadowy," somewhat like non-Gram-retaining bacilli after using that stain. This method was better than Pappenheim's, as there was no possibility of confusing different varieties of cells; but both methods were used to check each other.

Other methods recommended to show the mast-cells more especially are with dahlia (Ehrlich's original staining for mast-cells) and thionine (Darier).

To stain the elastin, Weigert's method, both with and without counter-staining, was used; the most satisfactory counter-stain was found to be saffranin or van Gieson's. To demonstrate the keratohyalin, and the changes in the collagen, the hæmalum-Hansen stain was adopted (*Joseph Derm. Technik*, p. 61).

(To be continued.)

SPIROCHÆTE IN SYPHILIS.

BY J. L. BUNCH, M.D., M.R.C.P.

SINCE the appearance this year of the paper by F. Schaudinn and E. Hoffmann, in the *Arbeiten aus dem Kaiserlichen Gesundheitsamte*, proclaiming the discovery of a spirochæte in syphilitic affections, much attention has been drawn to the question of a specific organism of syphilis and the claims which can be maintained in favour of the specificity of the *Spirochæte pallida*. The contagiousness of the disease and the nature of the eruption led to the belief, even long ago, when bacteriology was unknown as a science, that syphilis must be caused by a living virus, and in the sixteenth century this was called the "contagium animatum." In 1878 Losterfer published, in the *Arch. f. Derm. u. Syph.*, an account of some refractile bodies which he found in the blood of syphilitic patients and which he considered to be of diagnostic importance. In 1897 some larger non-nucleated bodies were described by Winkler as being present in syphilitic glands and chancres, and two years later Kutznitzky published an account of some bodies which varied from a comma to a semicircle in shape and resembled malarial plasmodia. The refractile bodies of Losterfer were accorded support by Neudörfer, who found them in more than 100 cases of syphilis some weeks after infection, and stated that they diminished in number during treatment with mercury. On the other hand, it has been stated that such bodies only occur in cases of syphilis which are accompanied by anæmia, and that they occur in anæmic patients who are not syphilitic. A motile element resembling *Amœba proteus* has been described by Beddoes and De Korté in the *Lancet* of September 9th, 1905. Small naked masses of protoplasm, varying in size, unstained, of a greenish hue, with finely granular contents, and without apparent nucleus, with very active movements, such as the putting out of pseudopodia, were found in excised chancres and secondary papules. If the patient has taken mercury, the motility, the most distinctive feature of the element, will be inhibited. A characteristic protozoon has been found by Siegel* in the blood, papules and chancres of syphilitics, varying in size from $\frac{1}{2}$ to 1μ , mostly pear-shaped and sometimes flagellated.

* Siegel, *Drei Monographien d. Königl. preuss. Akad. d. Wissensch.*, 1905.

In contradistinction to the amœba-like bodies described in the foregoing, the "contagium animatum" has by other observers been identified in different forms of bacteria in syphilitic patients. A species of coccus was described in syphilitic lesions by Birch-Hirschfeld, by Barduzzi, and by others, but in 1885 the bacillus of Lustgarten first aroused general interest. Markuse and some others have upheld the specificity of this bacillus, but Klemperer and others denied its presence in syphilitic tissues, and maintained that the organism in syphilitic secretions was the smegma bacillus. In 1891 a bacillus was also described by Marschalko, and in 1903 one by de Lisle and Jullien. Cocci have also been discovered by several observers, among others by Ferrari and by Levi, who both thought they were specific for the disease. Streptococci were found in hereditary syphilis by Kassowitz and Hoehsinger, but Koliseo thought they were ordinary streptococci and not pathogenic for syphilis. In 1901 Paulsen cultivated acid-fast bacilli from the blood of syphilitic patients, and in 1902 Joseph and Piorkowski asserted that the bacillus which they cultivated from the sperma of syphilitics, and which appears to have resembled Paulsen's, was specific. But inoculation on man of these organisms does not seem to have given a positive result, and it appears more probable that they are pseudo-diphtheritic bacilli.

The short shrift accorded to so many previous discoveries of the organism of syphilis rendered a certain amount of scepticism pardonable when Schaudinn's discovery was announced; but it has, at any rate, aroused general interest, and many observers have confirmed its presence in syphilitic lesions of various kinds. The difficulty of staining it has, perhaps, lent an additional interest, and has attracted the attention of bacteriologists in many countries. The *Spirochæte pallida* undoubtedly differs from other spirochæte which occur in non-syphilitic lesions, and may be known by its delicacy and by its staining reactions. It varies in length from 5 to 15 μ ; its maximum thickness is said to be $\cdot 25 \mu$, but usually it is too small to measure. It may have seven to twenty fine corkscrew coils, which are sharp and regularly spiral. The extremities are fine and tapering, as distinguished from those of the *Spirochæte pseudo-pallida*, which are rounded. The *Spirochæte pallida* can be found in the blood of syphilitic patients if this is received into sodium citrate solution, centrifugalised, and films made from the deposit stained by Giemsa's

method. The organism may be attached to a red blood-corpuscle, and Ploeger has suggested that the spirochaete may be disseminated through the agency of the erythrocytes. Longitudinal division of the *Spirochaete pallida* is said to take place, like Schaudinn's description of what takes place in *Spirochaete Ziemanni*, and therefore suggesting an affinity to the trypanosomata, which is further borne out by the well-known characters of the disease caused by the *Trypanosoma equiperdum*, which can be transmitted sexually. In unstained specimens the spirochaete is motile, progressing by means of a flagellum attached to either extremity. The most satisfactory methods of staining are, after fixing for ten minutes in absolute alcohol or by osmic acid vapour, with Giemsa's or with Leishman's staining solution. The former must, with a 1 in 10 solution, be prolonged for about twenty hours; the latter, as also Marino's method, is more rapid. Sabolotni has devised a modification of Giemsa's method, in that he treats the slide first with 5 per cent. carbolic solution and then pours on some Giemsa solution, which he warms for a quarter of an hour; the spirochaete is then stained. Oppenheim and Sachs stain by pouring on an alcoholic solution of carbol-gentian violet and warm carefully over a Bunsen flame until steam arises. But of these methods the Giemsa and the Leishman are, to my mind, the best. By these methods I have been able to demonstrate the presence of the *Spirochaete pallida* in some cases of syphilis of Dr. Crocker's, which he has kindly placed at my disposal, and I have much pleasure in thanking him for his kindness. The cases are as follows:

CASE 1.—Male, aged 24 years. Had had chancre on pubes four months ago, which had left a well-defined oval scar. Syphilitic eruption very abundant over trunk; fewer lesions on limbs. *Spirochaete pallida* found in the lesion, and also in scrapings from a mucous tubercle on the tonsil, in the latter case accompanied by *Spirochaete refringens*.

CASE 2.—Female, aged 25 years, with lenticular syphilide. *Spirochaete pallida* found in scrapings from the lesion.

CASE 3.—Male, with papulo-squamous syphilide and scar of chancre on dorsum of penis. *Spirochaete pallida* found.

CASE 4.—Baby, aged 11 days. Congenital bullous syphilide on hands and feet, which appeared first as “blisters” two days after birth. Mother had another child with an eruption said to be similar twelve months ago; this child died. *Spirochæte pallida* found in small numbers in the fluid obtained from previously unopened recent bullæ, but more abundantly in the scrapings from the floor of such a bulla. In bullæ which had been already opened the spirochæte were mixed with numerous other organisms.

CASE 5.—Male, who had had a papular syphilide for over a month, and had been taking mercury for the last six weeks. No spirochæte found in the scrapings of two papules.

CASE 6.—Male, aged 17 years. Through the kindness of Mr. Astley Bloxam I was present at the Lock Hospital when patient's primary chancre was excised, and was enabled to demonstrate the presence of *Spirochæte pallida* in plasma exuded from the chancre.

It is noteworthy that in these cases the spirochæte *pallida* was found more readily in the deeper layers of the lesions of a syphilitic eruption, and therefore further removed from the possibility of surface contamination, and occupying a position which lends more probability to their having been carried thither by the blood-stream. Case 4 is of interest from the position in which the spirochæte were found, and would have been of greater interest if I had been able to examine the liver after death. In a similar case of Levaditi's the greatest number of spirochæte was found in the liver, and from this, taken with other arguments, the conclusion has been drawn that the fœtus is probably infected with syphilis through the placenta.

These cases are few in number, and only merit consideration when taken in conjunction with the already considerable number of positive results which have been obtained by other observers in man and the observations of Roux and Metschnikoff at the Institut Pasteur on apes. There is a strong probability that the *Spirochæte pallida* plays an important part in the etiology of syphilis, and a great step in advance will have been taken if in the future it should prove possible to obtain cultivations of the spirochæte, but up to the present it has not been possible to cultivate any of the spirilla, although they occur abundantly in relapsing fever and elsewhere.

SOCIETY INTELLIGENCE.

THE DERMATOLOGICAL SOCIETY OF LONDON.

AN ordinary meeting of the above Society was held on Wednesday, October 11th, 1905, Dr. T. COLCOTT FOX in the chair.

The following cases and specimens were exhibited :

Dr. S. E. DORE showed a *case for diagnosis*. The patient was a man, aged 65 years, who presented himself at Dr. Pringle's Clinique at the Middlesex Hospital with an eruption on the left thigh, which had been slowly extending for twenty-five years. There was also a patch of about one month's duration in the popliteal region of the right leg. On the left thigh the eruption consisted of a dull red patch, resembling proriasis, but without much scaliness, and with marked lichenification and epithelial thickening, and a notably gyrate, well-defined edge. The skin of the scrotum was also affected, and there were several small outlying patches. The latter as well as the popliteal patch lacked the conspicuous thickening of the larger affected area. The lesions were superficial, and completely disappeared on pressure, although in parts they had somewhat the appearance of a granuloma. Except for slight itching, the patient was not troubled by the eruption. No cause could be found to account for the condition, and no diagnosis was made, the suggestion being that it probably belonged to the "parapsoriasis" group.

Dr. COLCOTT FOX brought (1) a healthy, well-developed lad (A. R—), aged 17 years, with an eruption distributed all round the legs from the knees to the ankles, of several years' duration, and unaccompanied by any disorder of sensation. A general view disclosed a yellowish-brown discoloration in irregular areas with outlying punctæ. Minute examination disclosed a number of isolated red punctæ, which were apparently blood-vessels. Their aggregation could be traced, and the gradual formation of sheets of tawny pigmentation with some slight superficial thickening of the part and roughness of the surface. The exhibitor was inclined to the view that the primary lesion was the prominence of a small vessel; that this disappeared, leaving pigmentation and some slight structural superficial alteration of tissue. The circulation was good, and the cause was obscure. Possibly the

condition was allied to the condition described as infective angioma by Mr. Hutchinson, but there was no lacework pattern in this case. The lad had only been seen that afternoon.

(Note.—Subsequent to the demonstration the exhibitor has refreshed his memory by reading again the account of "A Peculiar Progressive Pigmentary Disease of the Skin," published by Dr. Jay F. Schamberg, in the *British Journal of Dermatology*, January, 1901. There can be little doubt the exhibitor's case is an example of the disease described by Schamberg.)

(2) A single woman, aged 27 years, who was the subject of so-called *neurotic gangrene*. She was a tall, well-built, healthy-looking woman with quiet manners. Nine months ago she complained of pain at her left instep, and a medical man treated her with liniments, but without effect. Eventually he raised a small blister, which resulted in a small sloughing ulcer, and then other ulcers evolved up the leg. The doctor lost patience, and another medical man admitted her to a cottage hospital, where she was treated with creolin leg baths, and the ulcers healed. About a month after her discharge ulcers formed again on the same leg, and she was readmitted on her own request. This time treatment proved inefficacious. Iodide of potassium and Donovan's solution were given and Ung. hydrargyri applied without a cure. A new ulcer formed each week or so. She was carefully watched, but no malingering detected. She was very hysterical, and apparently had agonising pain at her monthly periods, and suffered from very troublesome constipation. Finally she was sent up to the exhibitor.

When first seen she presented a number of scars, more or less rounded or irregular in shape, from a shilling to a two-shilling piece in size, distributed up the front and sides of the left lower extremity from the foot to hip, and there were one or two on the left flank. There were one or two superficial ulcers about the knee-joint and just below a recent rounded area of white gangrene, the size of a two-shilling piece. No evidence of neuritis or anæsthesia could be detected. At each subsequent interview she has presented a fresh gangrenous patch, rounded or slightly irregular, at the sides or front of the knee region. She says she knows they are going to form on account of a burning sensation.

The exhibitor said he was not as yet in a position to prove the artificial production of these lesions, but a somewhat extended experience of similar cases since he published a paper on "Erythema

Gangraenosum," in Bulkley's *Archives of Dermatology*, convinced him that it was a *Dermatitis artefacta*. He founded this belief on the special features of the case and on the fact that he had positive proof in several similar cases of the causation. In a lecture on "Feigned Skin Diseases," reported in the *Illustrated Medical News* for 1889, he had given the sequel of one of the cases published in Bulkley's *Journal*. A bottle of sulphuric acid was found in the drunken woman's bed.

Mr. GEORGE PERNET showed (1) a microscopical section from a case of *Nævi cysteipitheliomatosi disseminati* (Lymphangioma tuberosum multiplex of Kaposi, hidradénomes éruptifs of Jacquet and Darier, etc.). The details of the case will be published as a separate paper.

(2) A girl, aged 9 years, cured of a patch of *Tinea tonsurans* (microsporon) by one application of the X-rays. The child was first seen in July with a single patch of ringworm, about 1½ inch in diameter, situated on the vertex. It was exposed for twenty minutes on July 17th, until the Sabonraud-Noiré pastille had almost reached the regulation brown tint. On July 28th the hairs were found to pull out easily; there was a little redness and soreness about the patch. Up till then a sulphur, resorcin, thymol ointment had been used. A dilute boric acid ointment with resorcin gr. v ad ʒj was substituted and continued during August. On August 4th the patch was practically bare; there was some pustulation here and there. The child was not seen again until October 10th, when the hair was found to be growing in the normal set, and there was no sign of disease present.

Several other members present stated that they had also had quite satisfactory results by using Sabonraud's method and pastille.

Dr. WHITFIELD said he had not seen pustulation with ordinary microsporon cases, but a moderately severe reaction occurred in a case of endothrix of the scalp of the inflammatory type, and a case of ectothrix of the beard at the hospital had also developed a severe inflammatory reaction.

Dr. RADCLIFFE-CROCKER and Mr. GEORGE PERNET showed a case of *Mycosis fungoides*, already exhibited on two previous occasions, viz. at the July and October meetings, 1904.* He had been treated by the X-rays only, and the infiltrated diseased areas had involuted, leaving an atrophic area in the middle of the back where the main patch had

* Vide *British Journal of Dermatology*, vol. xvi, 1904, pp. 348 and 422.

existed. The man, aged 29 years, was now brought before the Society on account of a recrudescence of the disease. On September 8th last he came to the skin-department with a history that three weeks before a fresh outbreak of the disease had occurred about the upper part of the arms. In this situation there were numerous discrete infiltrated areas, especially on the extensor surfaces. On the sides of the trunk there were many circinate and crescentic granulomatous infiltrations, which were here and there coalescent. On the back the fresh eruption was very marked, consisting of discrete lesions and rings. The eruption was florid and distinctly raised. The legs presented some papular lesions and scaliness. The post-sternomastoid glands were slightly enlarged. There was marked inguinal and some femoral adenitis. On the prepuce were two old scars resulting from a bicycle accident. Throat—*nil*. According to the patient, the present eruption had come out after getting very wet. Such recrudescences were interesting from the point of view of the action of X-rays on the disease. Notwithstanding their long-continued application, the infection or toxæmia was again manifesting itself by a more or less generalised florid eruption. Under the influence of the X-rays, the rash was now involuting. The patient had had no other treatment.

Dr. SEQUEIRA showed *two cases for diagnosis*—(1) a baby (female), aged 15 months, with a peculiar infiltration of the skin of the left upper arm. At birth a nævus was present close to the inner side of the insertion of the left deltoid muscle. The skin was raised and of a pink colour over an area as large as a halfpenny. Vaccination was performed when the child was 14 weeks old; the inoculation was made in four places, the two lower being just above and to the outer side of the nævoid area. The vaccination was made with calf-lymph and “took” well. Healing appeared to be complete at the end of three weeks. Immediately afterwards the arm is described by the mother as having swollen up from the shoulder to the elbow. The swelling was red and hot and the infant was evidently in pain. Under local treatment the swelling gradually subsided at the lower, but persisted and apparently spread at the upper part, towards the axilla. As no improvement had taken place after more than twelve months tuberculosis was suspected, and on October 10th the child

was brought up to London. The skin of the upper and inner aspect of the arm showed an irregular raised area of dark red colour. The lesions were hard and brawny, with very well defined margins. There was a little tenderness at the axillary border. The surface of the affected area was covered with rather long hair. There was no glandular enlargement. The child was in perfect health. The father and mother are quite healthy. Two other children were prematurely born, both at the seventh month. One was stillborn and the other lived a few days only. The case excited considerable interest, and the members present agreed with Dr. Sequeira that both tuberculosis and keloid could be excluded, and that the case was one of *nævus*. By some the opinion was expressed that the vaccination had set up an inflammation in the *nævus*, and by others the inflammatory condition was considered to be an independent phenomenon.

(2) A boy, aged 14 years, suffering from an ulcer of the umbilicus, with a peculiar scaly eruption on the trunk and extremities. It is hoped that this case will be published later, when the details have been worked out.

Mr. SICHEL showed (1) a case for diagnosis. The patient was a woman, aged 23 years. There was redness, roughness, and thickening of the skin about the tip of the nose. It began about twelve months ago, when she noticed it was getting red. It was considered by most of those present to be a tuberculous affection.

(2) A case of *rodent ulcer healed by treatment with X-rays*.

CURRENT LITERATURE.

MELANOMA. JAMES C. JOHNSTON. (*The Journ. Cut. Dis., inc. Syph.*, January-February, 1905.)

THE term "melanoma" was first used by Virchow to cover all sorts of pigmented neoplasmata, and the author thinks it may be well to retain this non-committal title until the controversy as to histogenesis of melanotic growths is finally settled.

The view is generally accepted that pigment tumours arise from two sites only, viz. the uveal tract (about one third originate in the choroid) and the skin including its invaginations to meet the hypoblast; that their metastases are equally widespread; and that in point of malignancy there is little to choose between them. The disease leads to a fatal termination in an average of about

three years, but there is a great difference in malignancy in pigmented growths, some spreading locally like a rodent ulcer. There are pigmented fibromata and kerato-acanthomata which never exhibit malignant tendencies. Melanomata, though by no means all, undoubtedly arise in soft moles, and the nævus is the structure to which study must be directed in the attempt to determine the histogenesis of melanoma.

After these general considerations the author reviews the various writings bearing on the origin and structure of soft moles, and gives the results of his own researches derived from the study of nine carefully selected pigmented nævi, and of sections of twenty other moles lent him by friends. He is convinced that there is no histogenetic relationship between the epithelial changes noted over the tumour and the tumour production. He believes there is a continuity of structure between lining endothelium and groups of nævus cells, which must be regarded as convincing, at least for the moles in which it occurs; and there are other considerations which point to a lymphatic endothelial origin for those cells. Then follows a discussion on the origin of the pigment found in the nævus cells—its minute structure, and its relationship to tumour growth.

The factors in the malignant evolution of the moles seem to be—(a) the existence of a nest of cells of a type approximating the embryonic and an imperfect tension to hold their activity in check, and (b) irritation with reactive inflammation. Finally, the author reaches the following conclusions:

(1) Aside from the natural division into choroid and skin tumours, melanotic neoplasms, which, from their diversity of origin, are best called melanomata, show several varieties.

(2) The commonest, and therefore most important, are those derived from soft nævi, which are endotheliomata, of lymph-vessel origin. Nævo-melanoma, whose histogenesis it is not possible to determine, must be referred to the same origin.

(3) A second variety exists with the same histological pictures, which does not spring from nævi, and whose origin is directly traceable to endothelium, probably also lymphatic. This group includes melanotic whitlow and the malignant lentigo of the French.

(4) The third division is truly epithelial in origin, although its existence has been denied. These tumours are of various types, and show only a very slight local tendency to malignancy, a fact sufficient in itself to determine a cardinal difference from the melano-endotheliomata, whose capacity in this connection can hardly be exaggerated.

(5) A histological diagnosis is the only proper method of differentiation between the two.

The paper is richly illustrated by microphotographs and two coloured plates.

T. C. F.

ON LICHEN SPINULOSUS. F. LEWANDOWSKY. (*Arch. f. Derm. u. Syph.*, February, 1905, p. 343.)

THIS contribution on Lichen spinulosus has already been referred to in this journal by Adamson in his recent paper on the subject. It is of interest since the writer holds the view that this affection is essentially inflammatory in nature, and that the para- and hyper-keratosis, which are responsible for the clinical

features of the disease are secondary. Three stages in the evolution of the lesion are described—an initial stage of œdema of the outer root sheath and parakeratosis of the funnel of the follicle; next an inflammatory reaction around the follicle, sometimes associated with intra-follicular pustulation; finally an absorption of the pus and a drying of the moist, imperfectly cornified lamellæ to form the spine. The paper is based on a case which occurred in Jadassohn's clinic at Berne, and the histological appearances are illustrated by reproductions of several drawings.

J. M. H. M.

ON THE HISTOLOGY OF RHINOSCLEROMA. H. SCHRIDDE.
(*Arch. f. Derm. u. Syph.*, January, 1905, lxxiii, p. 107.)

IN this contribution the writer briefly describes the clinical appearance of a case of rhinoscleroma which was peculiar in that the nasal affection, instead of being hard, was soft and ulcerated, an occurrence which has also been observed by Paltauf and Juffinger. The patient was a woman, and she came from Cassel, in Germany. The histological characteristics were similar to those which have been repeatedly described, namely, an infiltration of plasma-cells, large degenerated cells known as Mikulicz cells, cells showing hyalin degeneration, and the presence of a bacillus, closely resembling Friedländer's pneumo-bacillus. The only unusual histological feature was the absence of the dense mass of collagen which is usually present in the lesions, and gives them their hardness. An examination of the tissue led the writer to the following conclusions:

(1) That the Mikulicz cells were developed from plasma cells, and were produced by a mucoid degeneration of the plasma-cells.

(2) That this degeneration was the result of the presence of the bacillus of rhinoscleroma in the plasma-cells, and the action of its toxin.

(3) That the plasma-cells contained neutrophile granules, and from these the hyalin bodies were formed.

(4) That the bacilli were present chiefly in the Mikulicz cells, but also in plasma-cells, and free in the tissue, but that they were absent in cells which had undergone hyalin degeneration and in leucocytes.

J. M. H. M.

MONILIFORM HAIRS. F. BERING. (*Archiv f. Derm. u. Syph.*, May, 1905, p. 11.)

THE patient whose case forms the basis of this contribution was a boy, aged 5 years, whose mother had noted a peculiar nodular thickening of his hair soon after birth. The father of the boy suffered from the same affection, and also the father's sister. At birth the child's hair appeared to be normal. On examination a distinct hyperkeratosis at the mouth of the follicles was detected. This was most marked in the hairs near the forehead, while at the nape of the neck this was replaced by a slight hyperæmia of the margin of the scalp. The hairs were of the typical moniliform variety. The eyebrows were normal, as also were the lanugo hairs.

On microscopical examination a chronic inflammatory disturbance was noted around the follicle and the sebaceous glands were atrophied. The funnel of the follicle was plugged with a cornified mass, and the writer considered that it was

the pressure exerted by this mass which determined the moniliform changes in the hair—in other words, that the affection was the result of a Keratosis follicularis.

J. M. H. M.

THE INTRAVENOUS INJECTIONS OF MERCURIAL SALTS IN THE TREATMENT OF SYPHILIS. BARTHÉLEMY and LÉVY-BING.
(*La Syphilis*, February, 1905.)

OCULISTS, such as M. Abadie, believe that this method is destined to replace all others in the treatment of syphilis. The salts which have been so far used are: (1) the sublimate; (2) the cyanide; (3) the benzoate; (4) the hermophenyl. The cyanide is the most toxic of all mercurial salts and has often given rise to dysenteric diarrhoea. The sublimate coagulates the blood-serum. The benzoate is more difficult in preparation, and the hermophenyl is totally inefficient in its therapeutic action. Of these preparations the authors have tried to replace the cyanide by the oxycyanide, as being less toxic and richer in mercury, but were forced to discard it on account of the diarrhoea it gave rise to. A salt which is to be injected directly into the blood-stream should answer to the following conditions: (1) It must be soluble; (2) it should not coagulate the albuminoids; (3) it should not be toxic; (4) it should be stable; (5) it should have a fixed and known valency of mercury; (6) it should be easy of preparation and readily sterilisable. They claim that the biniodide of mercury in aqueous solution (isotonic or not) answers most nearly to these requirements.

Their 30 patients received 408 injections on an average of 13 injections per case. Two were treated with the oxycyanide, 5 with the sublimate, 17 with the biniodide, and 5 with the sublimate and biniodide at the same time. All the cases were women aged from 17 to 33 years; or average age 24 years, and average weight 50 kilogs.

The urine was examined both before and after treatment. In two or three traces of albumen were found on admission, which traces disappeared during treatment. The cases were not selected, but comprised primary, secondary, and tertiary lesions. The injections were made daily or every other day. The oxycyanide was used in 1 cg. doses; the sublimate in 1 to 2 cg. (this latter dose in 2 cubic cm.); the biniodide in 1, 2, and 3 cg. doses per cubic cm. This large dose of the biniodide was always well tolerated and never gave rise to any toxic effect. The injection was made indifferently into the veins of the upper and lower limbs; once into the veins of the breast; in fact, wherever a suitable vein could be found. Renault says that intravenous injection is impossible in one in twenty cases. The syringe used was Luer's, with a 2 to 3 cm. needle of very fine calibre and with the point kept well sharpened and as short as possible. Renault uses very short needles $\frac{5}{16}$ of a cm., especially made for him by Galante, but the longer needle has the advantage of diminishing the risk of reflux of the solution into the perivenous cellular tissue. The injection is used at a temperature of 38° or 39° C.

The operation.—If at the bend of the elbow—the usual site—the limb should rest on the table, and in order to render the veins prominent, a rubber band is placed about four or five fingers' breadth above the bend of the elbow and fixed by means of pressure forceps. The selected spot is next washed with two cotton-wool

tampons, the first soaked in 1 in 1000 sublimate, and the second in ether. Having flamed the needle it may be inserted either separately or fixed to the syringe. In the latter case the syringe should not be completely filled, in order to allow aspiration to draw some blood into the body of the pump. The needle, whether it be introduced separately or mounted, should be seized by the shaft between the right thumb and index finger, while the left hand steadies the site for the injection. The needle must be pushed in very slowly and very obliquely, almost parallel with the vein. The moment the skin and the anterior wall of the vein are passed, one has a sensation of a sudden giving and freedom of the needle, which should then be pushed on for at least a centimetre. In order to be sure that the needle is really within the lumen of the vessel, make a slight aspiration, and a small quantity of blood will flow back into the body of pump.

When the needle is really within the vein the pressure forceps, and so the rubber band, are released with the left hand, while the right pushes home the piston. The injection completed, the needle is rapidly withdrawn. With a tampon of wool slight pressure is kept on the little wound and the patient instructed to raise the arm vertically for one minute. The needle-prick is then touched with a drop of collodion, which serves the double purpose of occluding the wound and marking the exact site of the last injection.

Among the local troubles met with during a course of intravenous injections may be mentioned: (1) the vein may be perfectly visible and prominent; the needle introduced a trifle too rapidly penetrates, not only the anterior, but also the posterior wall; (2) or the needle introduced too carefully remains in the thickness of the anterior wall; (3) the needle may slip on the venous tunic and be lodged in the perivenous cellular tissue; (4) in some cases the vein is very mobile, and three or four attempts must be made before the needle rests in the lumen; (5) a sudden movement on the part of the patient may displace the needle; (6) a droplet of blood may coagulate in the needle. In all cases one must be certain that the needle is free and unlogged within the lumen of the vessel before making the injection. The injection should be *absolutely painless* and give rise to no local inflammation whatever.

If, with the injection of the first few drops, the patient complains of a sharp pain the operation must be immediately stopped and the needle rapidly withdrawn, for the solution has passed, not into the vein, but into the cellular tissue or into the wall of the vein. *Pain* is the one great sign that the solution has not reached the blood-current, and under these circumstances is always present, whatever the preparation used. Another symptom, of no less importance, of failure to reach the blood-stream is swelling at the site of puncture. The injection must be immediately stopped. The swelling disappears in about twelve hours, but the pains, very violent at first, may last several days.

It should be remembered that the patient may not speak of the pain, and then the first untoward sign will be the swelling.

The complications that may be met with may be divided into two groups: (1) local; (2) general. The local complications: (1) ecchymoses; (2) subcutaneous œdema; (3) local nodosities; (4) venous nodosities (periphelebitic); (5) sloughing.

Six of the 30 cases showed ecchymoses, varying in size from a fifty centime-pie to a five franc-pie. They appeared the day after the injection, lasted about five or six days, then disappeared, leaving no trace. They were slightly

painful for a couple of days, but never to a marked extent, and were probably due to some small escape of blood.

Five times subcutaneous œdema was noticed. This came on immediately after the injection and without any discoverable cause. It is a white, painful, maybe extensive œdema, lasting for eighteen to twenty-four hours, when it completely disappears, leaving at times some sensation of distress in the limb.

Seven of the patients had subcutaneous nodosities, varying in size from a pea to that of a small nut. They appeared one or two days after a badly-made injection and persisted for as long as a week or fortnight, and may possibly have been the result of not introducing the needle sufficiently far into the lumen of the vein.

Eight cases had periphlebitic nodosities, due also, probably, to escape of fluid into the perivenous tissue. They appeared one or two days after the injection, were painful, seriously interfered with movements of extension and flexion, and lasted on an average about two weeks. One case, indeed, still showed the induration two months after the injection.

One case, having received ten injections into the veins at the bend of the elbow without any complication, had such severe pains in the other arm as to necessitate stopping the treatment.

But the most serious complication is the cutaneous sloughing, and this always results from the escape of some of the mercurial solution into the cellular tissue or derma. It occurred seven times in the 408 injections—once in the leg and six times in the upper limb, once with the cyanide, four times with the sublimate and twice with the biniodide. The size of the sloughing varies with the amount of the fluid injected into the derma, from the size of a pea to that of a five franc-piece and larger. After an injection, which has been either painful or accompanied by swelling, or both conditions together, one notices during the following twelve hours that the injection wound is inflamed. The next day a somewhat indurated patch is formed around the puncture, and this, becoming brown or black, is surrounded in its turn by a red peripheral zone. Finally an ulcer forms, and it may be three or more months before cicatrization is complete. These accidents have given rise to ankylosis.

The general complications are those common to all methods of mercurialisation. Dr. Balyer has seen a case resembling true dysentery, following a single injection of 1 cg. of the cyanide. Gravagna has entirely given up intravenous injections on account of the severe entero-colitis they set up.

In a *résumé* of the whole question of intravenous injections the authors are unable to agree with Tommasoli that a radical cure may be effected by this method. The dosage is not sufficiently intensive in many cases to prevent a relapse of the symptoms. It is especially indicated during the first two or three months of the disease, when the blood is virulent and contagious, forming, as it does, a real local dressing to the blood. Again, in certain forms of secondary headaches, which resist the action of iodide of potassium, it is useful. But for eye cases, for which it has been asserted to be the one and only treatment, Barthélemy and Lévy-Bing do not believe that it is in any way superior to intra-muscular injections. In practised hands the little operation is a painless one, but requires daily repetition. Absorption is rapid, and so is the elimination; the latter is too rapid, and as a result the patient is less efficiently mercurialised than by the

treatment of intra-muscular injections. In selected cases it is undoubtedly a useful addition to the methods of treatment, but for the majority of patients, owing to the rapid elimination, the skill required in performing the operation, and the lesser protection it affords, it cannot be compared with the advantages derived from ordinary intra-muscular injections.

As regards this method of treatment, it is interesting to remember that as long ago as 1896 Mr. T. Ernest Lane read a paper before the Third International Congress of Dermatology (see the *Transactions* and the *Lancet* for December, 1896) on the "Intravenous Injection of Mercury."

The 76 cases are fully reported on. One thousand injections of a 1 per cent. solution of the cyanide of mercury (the most toxic of all mercurial salts, Barthélemy and Lévy-Bing) were given. Fifty of the patients left the hospital free from symptoms, sixteen were much improved, four refused treatment, and in six it was impossible to bring the veins into sufficient prominence. The inconveniences experienced were slight—two cases of abscess and one of sloughing; in this last case the injection was made into a varicose vein on the dorsum of the foot. The cases were all male in-patients and not selected, being a consecutive series of patients in all stages of the disease.

Again, in the *Lancet*, February, 1899, Mr. (now Captain) Chopping, R.A.M.C., published a further series (84) of Lane's cases, with the same satisfactory results.

And, finally, in vol. lviii (1904) of the *Guy's Hospital Reports*, Dr. Fortesene-Brickdale has contributed a very interesting paper on the "History of the Intravenous Injection of Drugs."

A. S.

CORRESPONDENCE.

94, HARLEY STREET, W..

October 13th, 1905.

To the Editor BRITISH JOURNAL OF DERMATOLOGY.

DEAR SIR,—With regard to the streptothrix specimen brought before the Dermatological Society of London at the June meeting of this year (*British Journal of Dermatology*, July, 1905, p. 265), I should like to call attention to an important paper on "The Biology of the Micro-Organism of Actinomyces," by Dr. James Homer Wright (*Publications of the Massachusetts General Hospital*, Boston, vol. i, No. 1, May, 1905), which may not be known to all your readers.

Yours faithfully,

GEORGE PERNET.

THE BRITISH JOURNAL OF DERMATOLOGY.

DECEMBER, 1905.

A CONTRIBUTION TO THE STUDY OF URTICARIA PIGMENTOSA.

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(Continued from page 411.)

Rarity and distribution of the disease.—I have compiled a table of all the cases of which I have been able to find a record (*vide* appendix); I owe much of the completeness of this table to the excellent bibliography published by Blumer in his paper on the subject (*Monatshefte*, 1902, vol. i), where he has compiled a list of 83 cases. I have added from the literature which has appeared on this subject since that date other cases, which with Blumer's 83 above mentioned make now a total of 154. It is highly probable that I have missed several recorded cases, notwithstanding considerable industry expended in searching for them, so that that figure cannot be regarded as exhausting all the cases up to date; it will therefore be apparent that Urticaria pigmentosa is no longer the excessively rare disease which it has hitherto been usually described as being; but it remains notwithstanding one of the rare diseases of the skin. Possibly as a result of the circumstance that the disease was first recognised in England, or possibly because it is actually commoner here, there is a great preponderance of English records; of the 154 cases in the table 62 are of English source, including my own 14 cases. Next in frequency are the German

and French cases (39 and 24 respectively). In the United States the disease is relatively infrequent, since there are only 16 records emanating from American observers. The observations in other countries than these are still extraordinarily few (nine in all).

Incidence of age and sex.—Blumer has made an analysis as regards the age of onset of the eruption in the 83 cases he tabulates. It is very rarely congenital; 59 cases (71.1 per cent.) are recorded in which the disease appeared before the end of the first year after birth. It is probable that more than half the cases show the disease before the age of 6 months. In my own table, of 142 cases 79 are recorded as occurring at or before six months of age (55 per cent.). It is usually taught that the onset of the disease in adults is very rare, but the number of cases in which the disease has appeared after puberty has been steadily augmented, and the following list, compiled from my table, shows the proportion of cases in which the patient had reached puberty (13 years of age), a total of 22 cases, or a little over 14 per cent. Some of these 22 cases are, however, not universally accepted as examples of the disease.

Cases in which onset has taken place after puberty (13 years) :

Colcott Fox	onset at age of 15 years.		
Liveing	„	„	14 years.
S. Mackenzie	„	„	23 years.
Eddowes	„	„	28 years.
Rutherford	„	„	14 years.
Hutchinson	„	„	14 years.
*Graham-Little	„	„	35 years.
*Wallace-Beatty	„	„	13 years.
„	„	„	14 years.
„	„	„	23 years.
Robinson	„	„	16 years.
*Elliott	„	„	28 years.
Hallopeau	„	„	“adult.”
Darier	„	„	55 years.
„	„	„	16 years.
*Quinquaud	„	„	45 years.
Blumer	„	„	16 years.
Veiel	„	„	20 years.
Kaposi	„	„	13 years.

Lesser	onset at age of 37 years.
Dubois-Havenith	„ „ 38 years.
*Breda	„ „ 41 years.

The cases marked with an asterisk are of doubtful character.

With regard to the sex of the patients, the observations vary very curiously. Of the 62 English cases, 40 are males, 19 females; in 3 cases the sex is not recorded. Thus the disease was noted twice as often in males as in females. Much the same proportion exists in the American cases (11 males to 5 females). In the German cases the incidence upon males is less marked (17 to 15), and in the French cases the numbers are exactly equal (11 to 11). Taking all the cases together in which sex is recorded, of 138 cases 86 were male and 52 female; that is, nearly 61·7 per cent. of the cases were of the male sex.

Inheritance.—It is a well-known fact that anomalies of pigmentation are amongst the most readily transmissible of personal peculiarities. It is, therefore, a little surprising to find that inheritance seems to play no part in the causation of Urticaria pigmentosa. In only one case of which I have knowledge has evidence of parental transmission been recorded (mother and cousin of patient); and in only two observations have two or more members of a family been noted as suffering from the disease (Darier's observation, three sisters affected; Wallace Beatty's observation, two brothers).

Association with other peculiarities of pigmentation.—While anomalies of pigmentation are commoner in dark-coloured (white) races and in dark-coloured individuals, the converse seems to hold good with respect to this disease. The distribution is enormously greater in the Teutonic peoples, who are characteristically fair, than in the Latins, for example; and amongst individuals, when facts as to this character are recorded, it is far more often found in blondes than in brunettes. This has been my own experience as regards the cases here recorded, and the same observation was made by Raymond. I have not found many references to the occurrence of other pigmentary disorders in association with Urticaria pigmentosa. In two cases only have I seen pigmented naevi (Cases 9 and 10) which were present with the typical eruption of Urticaria pigmentosa. Morrow's case, after persisting for twenty years, developed numerous pigmented mole-like elevations (*British Journal of Dermatology*, 1896, p. 34). In Obser-

vation 13, Isabella G—, if this was certainly an example of the disease, pigmentation preceded and accompanied the eruption of the disease. Rona had a similar case (*vide* table, Appendix).

Clinical aspects of the disease.—It has been mentioned that the onset is, in more than half of the cases, before the age of 6 months, in about 70 per cent. of the cases before the end of the first year. The *mode of onset* is very various; in, perhaps, the majority of cases, but by no means very convincingly so, the first eruption has been urticarial in type, the pigmentation apparently developing later. Quite often, on the other hand, the macules have apparently appeared spontaneously without any previous eruption. The first lesions to appear have at times been bullæ, and their presence is recorded in a considerable number of the cases. I have, personally, never seen this phenomenon. Certain occurrences seem, in a few cases, to have preceded the development of the rash in a manner suggesting a causal connection between the eruption and the occurrence. In one of my own cases the rash came out acutely and suddenly after vaccination, certainly within a week of the inoculation, for it was noticed between the first and second visit of the medical man performing the operation (Observation 1). Pick had a similar case (Kaposi's *Festschrift*). In Lazansky's case, quoted by Raymond, the same antecedent is noted; in Woldert's case and Colcott Fox's case it was observed immediately after varicella; in Cutler's case, after measles. In a recent case of Breda's, of which I have seen only the short abstract in the *Annales*, the eruption was apparently directly due to fright in a young child, aged 3 months. In one of my own cases, an intelligent and nervous boy of 9, who had renewed attacks up to that age, a vivid history was given by the patient of his being down for a caning at school, and of his developing an acute invasion of "spots" in anticipation of his corporal punishment. Mr. Hutchinson, as is well known, is of the opinion that insect-bites are responsible for the appearance of the disease, but this opinion has not received much support. In another of the cases quoted by Raymond the rash came out after the administration of a sulphur bath. Jacquet was persuaded that in his case the administration of morphine injections to the mother during her pregnancy was an exciting cause of the disease in her child. Perrin also is inclined to ascribe to maternal shock during pregnancy the development

of the disease in her infant. But far more often than not no persistent or frequently repeated precursor of the eruption is to be found. (For references in above quotations, *vide* Appendix.)

Since they occur usually in very young children, the subjective sensations connected with the onset are difficult to grasp. Usually the child appears quite well even while suffering the acute eruption. In one of my cases there were attacks of feverishness and general illness coinciding with fresh outbreaks of the eruption which in this case were frequently repeated. Similar instances have been recorded (Touton's Case, *vide* table, appendix) from time to time. Quite frequently there is no itching even at the first appearance of the eruption. This point will be dealt with later.

It is the rule for the eruption to develop in acute outbreaks; but in a case recorded by Darier in a girl, aged 16 years, the lesions first appeared in very small numbers, five or six on the abdomen, and slowly new lesions were added, until at the end of two years she had about 150 such. In my own case (Observation 11) *one* lesion came at the age of 3 months in a girl, and remained solitary for five years, when a second patch developed. She has never had any others, although four years have elapsed since the latter's appearance.

Character of the eruption.—Three types of the disease are usually described—(1) in which the eruption consists entirely of macules; (2) in which it consists entirely of nodules; (3) and a mixed form in which both types of lesions are found in one and the same case at the same time. Of 121 cases in which the kind of lesion present is specified, 83 were macular, 10 nodular, and 28 of the mixed type. It is sometimes difficult to say in a particular case whether there is or is not any elevation of the lesion—that is to say, whether one must describe it as macular or nodular. In my own cases the test I have applied is whether I could recognise the existence of the lesion by touch alone—with shut eyes. Any lesion not recognisable by touch alone I have regarded as macular.

Distribution.—It would be difficult to say that there are any "sites of election" for the appearance of the eruption, so varied is its incidence. The trunk is often the most extensively affected part of the body, and of the trunk perhaps the back is the most usually and most severely implicated. On the other hand, the parts least often invaded, and, if invaded, the latest to be attacked,

are the face, the palms, and soles. But it is too much to say that the face is "rarely" attacked; explicit record of this implication is frequently not made; but I am persuaded that it is because mention of the face is most often omitted that it is supposed to be rarely affected. I have made as far as possible a record of cases where the face is said to be free, or to be involved in the eruption as the case may be; it will be seen that the records of its involvement are perhaps unexpectedly numerous. Mr. Hutchinson, in fact, makes the statement that "the face rarely escapes." A confirmation of a supposed nervous origin has been sought in the tendency which the lesions sometimes show to run in oblique lines upon the trunk in the girdle axis of the body. Hallopeau pictures such a case in the *St. Louis Atlas of Skin-Diseases*, and considers that it argues a connection with nerve-distribution. On the other hand, Hutchinson has found in the peculiarly asymmetrical bizarre distribution which is certainly more usual a confirmation of his view that insect-bites, which would naturally follow no order, are the cause of this malady. His own statement that the face rarely escapes seems to me to be a strong argument against this explanation, for surely the face is very rarely the seat of the ravages of bed-insects, which uniformly prefer less exposed parts. In fact, it seems to me that if one approaches this question of distribution with a mind unenthralled by any theory, one is constrained to admit that beyond a certain predilection for the trunk, and a tendency to irregular and asymmetrical grouping, Urticaria pigmentosa shows no peculiarities of distribution which can be definitely formulated with our present knowledge.

In a certain proportion of cases, which would probably be larger if attention were directed to the point, lesions have been described as occurring in the buccal mucous membrane. I believe I have had such cases amongst those here recorded (Cases 2 and 5), but it is difficult to be sure, as the description of these lesions in the mouth is very vague. What I have seen have been small, brownish-yellow, apparently slightly raised patches on the mucous membrane of the mouth, with no subjective sensations attending them. No histological examination, as far as I know, has been made of these supposed mucous membrane lesions, and in the absence of this knowledge their nature must remain unsettled.

The typical lesion of Urticaria pigmentosa may be described as the

macule—that is, a perfectly flat stain. More rarely the pigmented patch is raised more or less sensibly from the skin, and thus constitutes a nodule; and in a certain number of cases both lesions—macular and nodular—may co-exist. Questions of colour, shape, size, surface, number, and involution of the individual lesions will now be considered.

Colour.—I have devoted a column in my table of cases to individual authors' descriptions of the colour of the lesions, from which it will be readily seen that they are mainly variations on the theme of brown, all shades, from brown-yellow through brown to deep brown-red being recorded. As a rule the colour is homogeneous, all the lesions being recognisably of the same colour; but not infrequently in the various cases some lesions, especially when on the lower extremity, are darker than others. The colour is very evanescent and difficult to fix in a description, because the lesion when irritated becomes reddened and then may temporarily lose its brown colour, being suffused with red. This is one of the most characteristic features of the disease, and one of great clinical importance, since it helps to distinguish other circumscribed pigmentations from those of Urticaria pigmentosa. In describing the colour of the lesions under consideration care must be taken to discount this temporary reddening, which may result from the friction of clothes, or possibly even from the exposure to cold caused by stripping the body. The nodules tend to be deeper in shade than the macules, probably because, as will be pointed out later, the nodule has a deeper infiltration of mast cells than the macule. In the nodular type a zone of redness occasionally surrounds the nodule (Case Edward W—, Observation 8). I have not seen this feature in the macule, but it has been described.

Shape.—The macule and nodule are most often oval or circular, when the lesion is small and well defined. In the less definite eruptions, as, for example, in Case 1 of my series the shape of the patches is very various and irregular; the most fantastic figures may be formed by the patches in such cases. Occasionally, especially in the nodular variety (for example, Case Cecil B—, Observation 4), the lesions are triangular and polygonal in outline, with a strong resemblance to keloid in the multiplicity of shapes they may assume. The lesions are usually discrete, but may become

coalesced and form large placards on the skin. This may happen both in the macular and nodular type, though naturally commoner in the first variety. In some of the cases recorded the diseased skin exceeded in extent of area the skin which appeared to be healthy, so that only small portions of the body appeared unpigmented; but I have not found any record of an absolutely universal pigmentation.

The *size* of the lesion varies as much as the shape, but is often approximately constant in the same person; that is, the eruption in any particular case will be fairly homogeneous. The patches do not apparently grow larger as they grow older; in the case Emily F— of my series it was possible to watch the two patches which constituted the whole eruption for years; no change in size was perceptible. The descriptions used for psoriasis may be borrowed for this disease, and a guttate, a nummular, and an areate variety may be distinguished. If the case commences as a guttate type it will probably remain guttate; if it commences with a larger lesion (nummular) as its habitual form, it will persist as nummular throughout its course for the most part. The size of the lesion is more constant in the nodular variety, and is usually smaller than the macule when the lesion remains discrete; but in the extraordinary case figured in the plate (Edward W—) nodules were formed, by coalescence of individual lesions, which reached an excessive degree of development, isolated tumours an inch and more in diameter being formed in this way. This, however, was an extremely exceptional case, and it is usual to find the nodules small and discrete; there is never the formation of plaques the size of the palm of the hand, for example, which is found in the macular variety, as occurred in the case of Alice B—, Observation 1, of this series.

The intervening skin between the nodules and the macules, even when it appears perfectly normal, may actually be diseased to a degree appreciable by microscopic examination, if the evidence obtained in the cases of Lilian C— and Cecil B— should be confirmed by other similar results. In these cases a piece of the apparently healthy skin, as far removed from the diseased areas as possible, was examined. It was found that there was very considerable pigmentation of the skin in the one, and a distinctly

abnormal number of mast-cells in the section in both cases, although these did not nearly equal the massed accumulations of these cells, which were seen in the sections of the actual lesions from the same cases (*vide infra*, discussion on histology).

Surface.—Raymond pointed out the “chagrinated” appearance of the lesion, and this peculiarity I can confirm from my own observations, and it seems, in fact, corroborated by microscopic examination; the distinctly rugose epidermis of the majority of the sections was a striking feature. The presence of small (microscopic) tumours, corresponding to the underlying masses of mast-cells, would appear to explain this “chagrinated” surface. It was noticeable, however, that in the two cases of definitely nodular type the surface was “shiny” and tense (so much so that the nodules were actually mistaken for fluid elevations by inexperienced students), and microscopically quite a different aspect of affairs was found; here the epidermis was stretched tightly by the underlying mass of cells and the rugæ obliterated by tension.

Number of lesions.—These may be in uncountable multiplicity, or, as in the unique case of Emily F—, be restricted to a solitary example. (It is true that in this case a second lesion appeared after some years; but no more than two ever developed.) In a remarkable case described by Darier, he was able to observe in a man of 56, who had over 140 lesions, a fresh outbreak in which an increase of one fifth of the number was made by a single outbreak. Successive crops of lesions naturally increase the number present at any one time, since the older lesions do not fade before the advent of the new; the cases of very extensive eruption have thus usually been subject to repeated outbreaks.

Development and involution of the lesion.—In certain recorded cases it was possible to produce artificially new lesions by scratching the apparently healthy skin; as the wheals thus caused subsided pigmentation appeared and became permanent. In the spontaneous eruptions the lesions apparently reached their development very rapidly—within a few hours sometimes. The duration of the pigmentation, once this has been established, is usually measured in years. I have not personally ever observed its entire disappearance; but this has been asserted, somewhat dubiously I think, to be the rule. Morrow’s statement that in his case nodules

appeared, reached the size of a coffee-bean or almond and disappeared within three weeks, is unique. I have seen in the two cases of nodular type that I have described definite involution; in the first case the tubercles flattened down to macules, apparently as the result of an intercurrent attack of measles; in the second case there was considerable flattening after some months, but in neither case was there any diminution in pigmentation. The disappearance of the eruption will be considered more fully under the heading of Prognosis; what happens apparently is that the facility of producing urticarial reaction in the lesion slowly diminishes and ceases eventually; it is very rare to find a record of absolute disappearance of definitely pigmented patches. The tendency to have fresh outbreaks usually ceases long before there is any change in the already present eruption—Raymond says generally after the first year. The longest time I have found mentioned during which an eruption persisted was in a case of Darier's, where a man had had the disease for fifty years, and mast cells were found in sections of a lesion at the end of that period (*vide* Appendix).

In the case of Emily F—, I was able to make an examination of two patches, one which had lasted for about one year, the other for nine years. In the latter patch the infiltration with mast cells was distinctly less than in the first and with different arrangement, and the colour of the patch was probably lighter by lapse of time (*vide* p. 402, Fig. 18).

Scars.—The nodules or macules are said to disappear without leaving any permanent sign of their presence; but in a certain number of cases scars seem to have been left by the eruption. Hallopeau claims to have seen three such cases, and one of these is figured in the *St. Louis Atlas of Skin-Diseases*. In the table in the appendix the facts as regards scars, as far as these could be ascertained from the reports of the cases, are collected. It will be seen that in several cases scars have been reported (Hallopeau, Wallace Beatty, Crocker, Galloway-Brongersma).

Subjective sensations, in a disease in which most of the subjects are infants, are naturally difficult to apprehend. Itching is the sensation most usually described, but it is by no means universal, or even so common as the name "urticaria" would indicate. I have tabulated the statements of the observers of cases in which any record is made

of the subjective features. It will be seen that in a very large proportion of the cases the itching was either very moderate in degree or entirely absent. The itching is very rarely comparable to the itching of chronic urticaria in children, and I have personally never seen any such signs of scratching as are the rule in the latter disease. I have never, for instance, seen pustulation from scratching; or lichenification, such as, for example, occurs in prurigo; and am satisfied that *severe* itching must be regarded as a very rare symptom. What one mostly finds is that the child when stripped for examination scratches the exposed parts a little, but the usual history certainly is that the general health is undisturbed and the sleep normal, which could hardly be the case with much itching. It is, in fact, an old observation that the disease seems to occur in otherwise especially healthy subjects whose health remains unimpaired by the disease. I have once had a description of the lesions "smarting" in a boy, aged 9 years, who took an exceptional interest in his eruption, which he had had since early infancy.

Collateral phenomena.—Two symptoms which seem usually found in association with Urticaria pigmentosa are: (1) Dermographism, the convenient name given by French authors to the symptom of factitious urticaria, by which it is meant that artificial wheals may be readily induced upon the unaffected skin when scratched. This is not always present, but is certainly very frequent, and may be found without any spontaneous itching being complained of. It varies greatly in different cases. It must be distinguished from the important clinical symptom which is so largely helpful in diagnosis, namely that the lesions of Urticaria pigmentosa when scratched will redden and swell. Factitious urticaria and this symptom may, and perhaps usually do, co-exist, but one may be present without the other. The significance of dermographism is by no means clear. I have seen it present to the most extraordinary degree in a perfectly healthy person, a medical man, who did not suffer from urticaria, but could always readily produce exaggerated wheals on his body by trivial scratching.

(2) General enlargement of glands. This was noted in one of the earliest cases, recorded by Pick, and has not, I think, obtained the prominence which it deserves. I have found it almost always in my cases, sometimes to a degree only to be compared with the polyadenitis of secondary syphilis. The explanation which has been supplied, that

the glands enlarge in response to the suppuration caused by scratching, must certainly be abandoned, for I have repeatedly found this enlargement without the slightest scratching or pustulation. Moreover, the glands do not suppurate, but persist as hard, shotty swellings, exactly as in syphilis. I have thought that the occipital glands (in the posterior triangle of the neck) are especially often enlarged, and are especially characteristic; this has been observed in the youngest children, and careful exclusion of other possible causes, *e. g.* pediculi, has naturally been made. This polyadenitis fits in well enough with the theory of a general blood-disease; and it will be seen that some of the characteristics of the blood in this disease have been also found in cases of lymphadenoma. In some cases of lymphadenoma, moreover, cutaneous tumours have been described which, in a patient of the late Dr. Lee Dickinson's (*vide Transactions of the Clinical Society*, 1902) were pale yellow in colour. The sections of one of these tumours which I had the opportunity of examining (*British Journal of Dermatology*, 1903, p. 220) showed, in addition to the characteristic infiltration with lymphocytes, a distinctly abnormal number of mast-cells in the corium, though not to a degree comparable to the condition seen in *Urticaria pigmentosa*. These analogies are interesting in view of the results of the blood examinations detailed below.

Prognosis.—It is usually said that *Urticaria pigmentosa* disappears spontaneously after a certain number of years, variously estimated by different authorities. A certain source of fallacy exists as to what degree of involution may be regarded as equivalent to disappearance of the disease. Is the cessation of fresh outbreaks to be taken as the test of disappearance? Is it to be found in the loss of the characteristic reaction of the individual lesion to scratching? Or must one insist upon the absolute obliteration of the pigmentation before one can pronounce the disease extinct? Taking the last criterion as a standard, it is doubtful whether any case has been absolutely cured. I have abstracted from the literature whatever evidence I have found of a recorded "disappearance" of this disease. Morrow mentions a case in which nodules were found, "the size of a coffee-bean or almond, of a pearly lustre, giving a deceptive indication of fluid, but found to be solid upon pricking; some had the appearance of a solid lardaceous deposit, over which the skin was tensely stretched" (compare

the whole description with that of the lesions in the case of Edward W—, Observation 8, page 370). They would come and go with remarkable rapidity ; some would “*disappear*” within a week ; their average duration was three weeks ; but their disappearance seem to have been limited to a change from the nodular to the macular variety of the disease, since it is expressly stated that pigmented patches remained almost universal, only a portion of the skin being free. Morrow, seeing apparently the same case twenty years after, states that certain changes had taken place, especially in the disappearance of patches on the face : but they remained very largely upon the body.

Radcliffe-Crocker had one case which “got well within the first year, leaving cicatrices.”

In Levinski's case, in which repeated attacks had been a prominent feature, the lesions began to fade or to cease being urticarial after nine years. Unna's case, seen five years after onset, showed a fading of the stains from deep brown to pale yellow and a cessation of the itching (Raymond). Feulard's case, seen also five years after onset by Raymond, showed changes from tubercles to macules, which did not become turgid but did redden on scratching, and in which itching had sensibly diminished—“the old patches had paled a little, but not one of them had completely gone.” In Fournier's case Raymond also found that “the papules had lost their hyperæmic colour but not their pigmentation.”

Colcott-Fox saw a case in which the eruption had “almost entirely disappeared” after nine years ; and another case in a boy, in whom after ten years “only stains remained, which could not be excited to become urticarial.”

Pick reported a case as being “entirely cured” and as having remained without recurrences for two years.

Pye-Smith had a case in which, according to Raymond, he reported privately to the latter that the case “*aurait été guéri*,” but he had been lost sight of after three visits.

In Cavafy's case the disease had “diminished.”

In Barlow's case the disease had “ameliorated,” but the stains remained.

Hutchinson gives the most convincing evidence that I have found as to the actual disappearance of the lesions of Urticaria pigmentosa.

In two plates of the same case, the later ten years after the first, the face is copiously covered by the eruption in the first, and free from eruption in the second plate. The body remained pigmented.

As affording evidence, in the contrary sense, of the frequent persistence of *Urticaria pigmentosa* for far beyond its thus allotted span, I have compiled a list of cases (mentioned more in detail in the appendix) in which the disease had persisted for fourteen years and upwards at the date of the record :

Tilbury Fox's case	.	.	.	.	.	.	18 years.
Mackenzie's	„	.	.	.	.	.	14 „
Galloway and Brongersma's case	.	.	.	.	.	.	18 „
Lewinski's case	.	.	.	.	.	.	18 „
Blumer's	„	.	.	.	.	.	15 „
„	„	.	.	.	.	.	40 „
Rona's	„	.	.	.	.	.	20 „
Joseph's	„	.	.	.	.	.	19 „
Fabry's	„	.	.	.	.	.	19 „
Kreibich's	„	.	.	.	.	.	20 „
„	„	.	.	.	.	.	34 „
Jadassohn's	„	.	.	.	.	.	17 „
Cutler's	„	.	.	.	.	.	18 „
Sherwell's	„	.	.	.	.	.	23 „
Morrow's	„	.	.	.	.	.	22 „
Darier's	„	.	.	.	.	.	14 „
„	„	.	.	.	.	.	50 „
Petersen's	„	.	.	.	.	.	22 „
Lesser's	„	.	.	.	.	.	29 „

GENERAL HISTOLOGICAL CONSIDERATIONS.

A great number of cases (*r.* Appendix under heading “Histology”) of this disease have been examined histologically since the epoch-making publication of Unna in 1887, in which he announced the presence of mast-cells, in a very striking preponderance, in the corium. This feature has been recorded in an overwhelming proportion of the cases in which examination has been made, and it must be now accepted as an established fact that the presence of

these cells in this abnormal profusion constitutes a fairly certain indication of the character of the disease. For example, in the examination of Observation 11 of my series, when the entire eruption consisted of only two lesions, the diagnosis could only be definitely ascertained by the finding of these peculiar cells and was so ascertained. *Per contra*, the absence of this feature must be accounted an almost insuperable objection to making the diagnosis; and for this reason probably Quinquaud's case (*v.* Appendix) is generally considered a dubious example of Urticaria pigmentosa. In one other case, that of Lesser (*v.* Appendix), no mast-cells were found in the skin of a patient who was notwithstanding reported as being an example of this disease. With these two exceptions I have not been able to find any record in which the clinical diagnosis of Urticaria pigmentosa was generally accepted, and in which sections failed to show these characteristic cells when examined histologically. Neisser's suggestion to class the lesions of Urticaria pigmentosa under the heading of "Mastzellentumoren" seems worth adopting as an attempt to emphasise their essential character. If the description "tumoren" may be thought inappropriate for plane lesions it may be urged in its defence that the accumulation of mast-cells, even in the typically macular cases, constitutes microscopically a tumour. The arrangement of the mast-cells in the skin will be discussed elsewhere.

The *epidermis* has frequently seemed to be thinned over the masses of underlying cells when these approached the surface. This was especially the case in the two instances of nodular Urticaria pigmentosa recorded in the text; here the skin was definitely stretched and tense over the tumour-formation.

A feature which has been almost constantly present in my own cases, and which I have not seen noted elsewhere, has been the intra-cellular œdema of the epidermis, with occasional inter-cellular œdema as well. I am inclined to ascribe this feature to the circumstance that, the lesion being irritated in the process of preparing for the biopsy by the friction of washing and drying the lesion for excision, active turgidity (urticarial reaction) would necessarily be produced, which would perhaps be further increased by the subcutaneous injection of encain, and this may explain the constant feature of apparent œdema. Kerato-hyalin has been deficient in the majority

of my sections, the only case in which it was abundant being the nodular *Urticaria pigmentosa* present in C. B— (Observation 4).

Pigmentation.—The presence of pigment, it may be reasonably imagined, considering the established name for this disease, is as essential as the presence of mast-cells; but this is apparently not the case, unless we can suppose that the presence of pigment has been missed in those cases in which its absence is recorded. That it is comparatively easy to miss its presence will be acknowledged by all who have examined a large number of sections of the skin from cases of this disease, especially in sections stained with vivid nuclear dyes. Personally, my experience has been that the pigment-granules showed best in preparations stained with polychrome blue and alum, in which the stain was almost completely removed by decolourising in alcohol. The position in which the pigment-cells occur, and their number, seems to vary enormously and at times unexpectedly when considered in relation to the clinical features of the lesions. The race is not always to the swift, nor the battle to the strong; and it is certainly true that the lesions which clinically and to the naked eye appear darkest may microscopically have the smallest amount of pigment, while patches which seem almost too faintly coloured to be easily differentiated from the healthy skin may have a rich provision of pigment-cells. It will be often found that in the same section portions of the epidermis are almost without pigment, while closely juxtaposed portions have pigment-cells several layers thick. I believe that there is a rough agreement between the amount of pigment and the number of mast-cells—that is, that over the accumulation of mast-cells (where these are focally collected) the pigment-cells are increased in amount; but it was obvious in several sections that marked pigmentation was present in places where no mast-cells were visible. The pigment is found in special cells, consisting of a nucleus (stained faintly blue with polychrome methylene blue and alum) surrounded by granules which stain with the same method various colours from a yellow-green to nearly black. These cells are mainly found in the basal layer of the epidermis, but are not confined to this position; they may be seen in several of the superposed layers of the rete, and may also be seen free in the corium, usually quite close to the basal layer of the epidermis, and in the neighbourhood of mast-cell accumulation. The granules of pigment have been repeatedly

demonstrated to be melanin. The shape of the pigment-cell differs; in the rete the nucleus and granules constitute a columnar cell with the long axis vertical to the surface of the epidermis; the granules are less copious than when the cells occur free in the corium, and here the shape differs also, the whole cell looking very like a mast-cell with fusiform and stellate shapes. Pigment is probably present beyond the margins of the actual disease, and it is even possible that the skin over the entire person may be partially pigmented, since in one case a portion excised from apparently healthy skin, as far removed from the diseased surfaces as possible, showed the presence of pigment (Case 2, *v. infra*).

Bäumer found that pigmentation was very variable, being especially pronounced in the parts of the nodule that had attained complete development. The pigment occurred in the form of fine grains, golden yellow in colour, forming a complete mantle around the nucleus; the pigment diminished *pari passu* with clinical retrogression of the lesion (*vide* table, Appendix).

Mast-cells.—These were found by Unna as a dense infiltration of the corium, the cells being identified by him as the mast-cells of Ehrlich. Their derivation was for a long period in doubt, two views, (1) that they originated from the blood, (2) that they were altered connective-tissue cells, being held. It has, according to Darier,* been demonstrated by Ranvier that they are derived from the blood; and this view receives confirmation in the observation, frequently repeated, that the cells are found surrounding blood-vessels. Even in the cases where this arrangement around vessels is not immediately apparent, as, for example, in the disseminated tumour type (Cases 4 and 8), it may usually be seen in sections at the margin of the tumour. The cells may be described as being of two types—(1) the fusiform, well-developed mast-cell, with normal nucleus and a copious granular mantle around it; with polychrome methylene blue the nucleus stains blue, the granules a purple-red; (2) the cuboid cell, which is supposed to have this shape from mutual pressure in large infiltrations; in this type the nucleus is surrounded by a thin outline of granules and the cell is distorted and compressed. Besides these types, which are readily recognisable, the infiltration may consist in parts of broken-up matter, ill-stained nuclei lying in granular debris

* Darier, *La Pratique Dermatologique*, Art. "Anatomy of the Skin."

with no definite form; but the staining reactions establish this *débris* to be of the same character as mast-cell granules, though the cellular formation may be lost.

Arrangement of mast-cells.—It has been noted that the commonest position for the mast-cells to be found is around blood-vessels which are often outlined by these cells, and therefore in sections so stained as to indicate only the mast-cells and none other, the blood-vessel is still quite conspicuous in the field. The superficial blood-vessels are perhaps more often and more copiously surrounded by mast-cells than the deeper vessels, but both are quite often simultaneously involved in this process. The cells may thus accompany the tiny capillary twigs into the summit of the papilla, and they have even been found in the epidermis itself (Jadassohn) as an interepithelial infiltration. More often the main bulk of the infiltration is found around the larger tracks of the subpapillary and deeper plexus. In addition to the blood-vessels, the hair-shafts and the sweat-glands and sweat ducts are usually more or less surrounded by mast-cells, possibly, I think, because these structures are richly vascularised, and may thus be expected to show this arrangement of cells if these are born in the blood-stream. The position of this infiltration, which is found more often around the hair-papilla than superficially along the hair, confirms the explanation offered, since it is here that the blood-vessels are most generously supplied (*vide* Fig. 18, where the hair-papilla is surrounded by mast-cells). Blumer has classed the cases of this type of infiltration under the heading of “mast-cell tumours (typus Unna),” as distinguished from another arrangement of mast-cells in which no special grouping of the cells can be recognised, but there is a general very copious infiltration of the corium (“disseminated mast-cells, typus Jadassohn”). It is, however, probable that these apparently different arrangements merely mark different degrees of infiltration, since the grouped type was found in the earlier sections from a case which later sections ultimately demonstrated was an indubitable instance of the disseminated type, and intermediate stages between the two types were present in some other cases. It happened in my own experience that the only two distinctly “disseminated” infiltrations occurred in cases of the clinically nodular variety of the disease; but I do not know whether the disseminated variety necessarily indicates the existence of nodules, and would question this conclusion from the

approximation to the disseminated arrangement found in sections from cases which were clinically distinctively macular. It has been mentioned that the colour of the clinical lesion was ascribed by some writers to the pigment-cells, by others to the mast-cell infiltration; and it will have been seen that my own experience inclines me to minimise the part in coloration of the lesion played by the pigment-cells, since in many of my cases the darker-coloured clinical lesions were associated with light-coloured and scanty pigment-granules, and *vice versâ*. It seems probable to me that the colour is due more pre-eminently, if not wholly, to the underlying mast-cell accumulations, and that just as the buff-coloured nodules which are apparent in cases of lupus when the patches are examined with the diascopé are probably due to the localised accumulation of plasma and other cells in the corium, so this coloration in Urticaria pigmentosa is due to these accumulations of mast-cells in the corium. It has, at any rate, seemed to me that there was a certain correspondence between the amount of the infiltration with mast-cells and the depth of colour of the clinical lesion. In a contrary sense Darier records his opinion that the mast-cell infiltration is greater in old—and presumably lighter-coloured lesions since the tendency is to fade—than in recent lesions. My own experience, however, in a case which gave exceptional opportunity of testing this point, was directly the reverse of this observation of Darier's. In the case of Emily F—, in which the entire eruption consisted of two lesions, the first examination was made from the section of the more recent lesion, which was then only some months old. The appearances of the section are figured in the text (Fig. 17), and the case was mentioned specially as forming a halfway meeting place between the disseminated and grouped varieties of infiltration. Later on I had the opportunity of examining in the same case the remaining macule, which had persisted for nine years, and in this a great difference was noted, the infiltration being on the whole scanty and confined to the neighbourhood of blood-vessels, hair-shafts and sweat-glands (Fig. 18, p. 402). In order to guard against the fallacy of mistaking marginal sections for those of the substance of the macule, serial sections were made at different levels throughout the excised portion, and this arrangement was found throughout. The pigment was also sensibly diminished in the sections from the later excision. I think that possibly the patch had also faded in colour,

since it was rather difficult in excising it to differentiate diseased from healthy skin, which had not been the case in the first excision; but this had been performed three years previously, so that my recollection may be at fault in this particular.

A very similar arrangement and scantiness of mast-cells was noted in the case of Thomas M— (Observation 5, fig. 9), in which the section was taken from a macule which had also lasted probably for much the same period as in this case (nine years).

In most of the cases the mass of mast-cells is found to be densest in the parts of the skin where the colour is clinically deeper—that is, in the centre of the macule or nodule. This observation of Jadassohn's has been abundantly confirmed in my sections; the mast-cells universally become thinner at the periphery of the lesions. But I did not find that pigmentation ceased as certainly beyond the limits of the clinically diseased patch, although there seemed to be a rough correspondence between the amount of pigment-cell production and mast-cell infiltration in the same section. As against this correspondence must be mentioned the cases where scanty pigment-cells were coincident with especially deep mast-cell infiltration (Observations 4 and 8).

Connective-tissue changes.—The blood-vessels have usually appeared dilated and for this reason unduly numerous, the smaller vessels showing up in greater numbers than in normal skin. In only one case was there any considerable extravasation of corpuscles into the tissues, a phenomenon which has been supposed to account for the colour of the lesions of Urticaria pigmentosa, a supposition which my sections certainly do not confirm. Neither was there any reason to endorse the view that deposits of hæmatin in the tissues were responsible for the coloration. I did not find this in any of my sections. The collagen appeared separated and spaced out, especially in the superficial part of the corium. This change, which was noted by Unna in his initial masterly investigation, has been repeatedly confirmed since that observation by Bäumer, Reiss, and others. This dehiscence of the collagen would seem to point to an interstitial œdema, which the dilated vessels would also confirm. In several places in the section actual cavities, not the result of injury in preparation of the section, exist. This condition is most marked in the position of infiltration with mast-cells.

The elastin is likewise dislocated and forced apart apparently by interstitial tension. In the lacunæ thus produced are found the masses of mast-cells, but the distension is distinctly greater than the actual displacement by the bulk of the cells would warrant, so that these masses lie in spaces bigger than they fill. This appearance varied in different sections, but was most pronounced in the cases where the infiltration was densest, and so was at its maximum in the two nodular varieties of the disease (Observations 4 and 8), where there was practically no elastin at all in the superficial parts of the corium, all of it being apparently forced back to form a sort of felted barrier in the deeper part of the corium. In many of the sections the elastin was broken up and swollen, but without showing the staining reaction of degeneration. Colcott Fox found the elastin fibres "stretched and ruptured" in his case (*British Journal of Dermatology*, 1898, p. 412). These appearances have been noted by other observers (*vide* Bänninger's case, Appendix).

(*To be concluded.*)

A NOTE ON TEAK DERMATITIS.

By WILLMOTT EVANS, M.D., B.S., B.Sc., F.R.C.S.,
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THE importance of the action of external irritants in the production of various forms of dermatitis is fully appreciated at the present time. Especially important etiologically are various substances and materials which, being employed in certain occupations, are liable to give rise to cutaneous manifestations in all those coming in contact with them, or, more commonly, in those only who are predisposed towards inflammation of the skin. For accuracy in diagnosis a knowledge is essential of the various occupation eruptions and their causes, so that even if the patient has failed to associate his skin condition with his work it may be possible for the physician to recognise at once this connection and to identify the individual causative agent. I venture, therefore, to bring forward the following case, as teak does not appear to have received much recognition as an exciting factor of a dermatitis.

A carpenter, aged 62 years, was admitted to my Out-Patient

Department at the Royal Free Hospital in July of this year complaining of a very extensive affection of the skin. It had commenced nearly a fortnight previously, on the backs of his hands, whence it had spread up the forearms to the chest and face, and a little later over the whole of the body and the lower limbs. At first there had been merely a redness of the skin, but the eruption had soon become moist, and it was accompanied by severe itching, and the scratching and rubbing which naturally followed had much aggravated the condition. On examination there was seen to be a severe dermatitis, especially marked on the backs of the hands, the face, and the chest, but it was almost universal. Where less severe, or where it had most recently appeared, merely an erythema was present, but where it was most marked the eruption was vesicular or showed ruptured vesicles, with many cracks and excoriations produced by the severe scratching to which it had been subjected.

A sedative lotion of subacetate of lead and calamine was prescribed, and in ten days the eruption had subsided, the itching had gone, and the patient was almost well.

When the patient was asked his opinion as to the cause of the condition, he expressed the conviction that it was due to teak, and he gave the following history: About ten years previously he had worked in teak as a carpenter, and then he had suffered severely from an eruption similar to that with which he was affected when seen by me. That attack had persisted until he gave up working in teak. The severity of the attack had been so great that for ten years he had refused to work in teak; but advancing years diminishing his chance of obtaining employment, and having been out of work for several weeks, he accepted an offer of some staircase work in teak. He had worked on the teak, which was very hard, for only two or three days when the dermatitis commenced on his hands and spread over the body as already mentioned. Of eight men who had worked on this teak at the same time, six were affected, though not all equally, and his attack was certainly the worst. He said that it was well known amongst carpenters that working in teak was liable to give rise to an eruption, and that it was the harder teak, such as used for steps, which was most likely to set up the dermatitis, and this was due, in his opinion, to the fact that the harder the teak the more it required to be rubbed with glass-paper to obtain a good surface.

This glass-paperying gives rise to a fine dust, consisting of minute particles of the teak-wood, and to this fine teak-dust he ascribed the attack. From this very circumstantial account I think we must draw the conclusion that working in the teak was the cause of his attack. His statement, too, that teak is recognised by carpenters as liable to give rise to a dermatitis supports this view. When, however, I proceeded to look up the literature of the subject I found that, amongst all the works I was able to consult, no reference existed to a tendency of teak to induce a dermatitis, though I may mention that I have been informed that in some skin-cliniques in London dermatitis due to teak is not rare. The only mention of teak in connection with a dermatitis occurs in a query appearing in the *Lancet* of April 18th, 1896, p. 1113, where the writer asks if anyone can inform him whether "carpenters working in teak occasionally suffer from a skin-affection similar to that described as resulting from handling *primula obconica* and affecting the face and arms." In the next number (p. 1193) he is assured, on the authority of a man with thirty years' experience in working in teak, that such a thing was never heard of, but that, if splinters from teak pierced the skin the wound was sure to inflame and suppurate, and in a later issue another correspondent expressed the same opinion as to the harmlessness of working in teak, but he also said that wounds from teak splinters healed quite readily and without inflammation or suppuration. Of course, this negative evidence is of but little value, as I would not for a moment contend that teak will at all times and in all people set up a dermatitis. It is clear that it does not, and it is probable that in the case described a predisposition existed to dermatitis which facilitated the action; still, if six out of eight can be attacked, the predisposition required cannot be great. It is probable that the quality of the teak varies greatly. Teak wood appears to be of two kinds; the softer, more superficial, wood seems to be harmless; it has little or none of the aromatic odour belonging to the harder and darker heart wood of the tree. This odour is due to an essential oil, which has been extracted and has been employed in India medicinally. It is almost confined to the heart wood, which is most employed for stair-treads, and it was while working in wood intended for stairs that the attack described above commenced. I think it probable that this aromatic oil is the essential cause of teak dermatitis, and I may recall the fact that the dermatitis,

excited by the *Rhus toxicodendron* is really caused by the oily substance, toxicodendrol, which can be obtained from the plant. In the case of teak, I have mentioned that the sap-wood contains hardly any teak oil, while the heart-wood is highly impregnated with it; and in this connection it is of interest to note that though the white ants will attack nearly every other form of timber in tropical climates, and will even eat the sap-wood of teak, they will not invade, except sometimes to a very slight extent, the heart-wood of the teak tree. This fact certainly suggests that the oil is the restraining influence, for it cannot be the hardness of the wood, as they will attack woods which are much harder than the heart-wood of teak. It would be interesting to know if the oil of teak when applied medicinally has ever been known to give rise to a dermatitis. I should also be interested in learning if any treatment can either temporarily or permanently *prevent* these forms of occupation dermatitis. The employment of gloves, leather or rubber, will sometimes prove sufficient, but not always. So far as I myself know, the only satisfactory prophylaxis is the complete avoidance of the cause.

SOCIETY INTELLIGENCE.

THE DERMATOLOGICAL SOCIETY OF LONDON.

A MEETING of the above Society was held on Wednesday, November 8th, 1905, Mr. MALCOLM MORRIS in the chair.

The following cases were exhibited :

Dr. H. G. ADAMSON showed a *boy, aged 11 years, with Lupus erythematosus*. The interest of the case was in the age of the patient and in the question of the differential diagnosis from *Lupus vulgaris*. The boy had had scarlet fever two years before, and the patch on the left cheek had appeared soon afterwards. At the centre of the left cheek there was now a patch of the size of a shilling, consisting of a marginal ring, made up of flat, red, slightly raised, contiguous areas the size of split-peas, surrounding a central pale, atrophic scar. The red margin showed no apple-jelly infiltration, and its surface was pitted with patent follicles and slightly scaly. There had been no

ulceration preceding the scar. In a corresponding position on the right cheek was a smaller, more recent, circular, slightly raised, red disc, a quarter of an inch in diameter, with a cribriform pitted surface. On the margin of each ear was a circumscribed, dusky, erythematous patch. The fingers were cold, but there were no lesions here or on the scalp. It was pointed out by some members present that there was also an erythematous patch on the mucous membrane of the right cheek—it was opposite a ragged decayed molar. The boy's face was white and puffy, and a trace of albumen had been found in the urine which had been passed in the forenoon. There were no physical signs of tuberculosis. The diagnosis of Lupus erythematosus was confirmed by the members of the Society.

Dr. S. E. DORE showed a case of *hypertrophic Lichen planus* in a man, aged 34 years. He presented three raised thickened patches about the size of a halfpenny, of a reddish colour and of an oval or circular shape, in the flexure of the left leg, the lowest lesion being situated in the popliteal space, and the other two about two and five inches respectively above this. The patches were flattened and slightly scaly on the surface, with elevated rounded edges and a well-defined border surrounded by a faint erythematous halo. The patient stated that they had begun as scaly spots, the size of a pin's head, about two years before. The early stage was exemplified by a thickened scaly papule, or agglomeration of papules, about the size of a pea, above the right outer malleolus, and a still smaller hard, scaly spot on the inner aspect of the left eyelid. The diagnosis was established by the presence of typical patches of Lichen planus on the buccal mucous membrane and a few characteristic angular papules on the forearms and legs.

The patient was in good health, and only complained of slight occasional itching of the patches. Some scaliness of his elbows was attributed to pressure and friction consequent upon his work as a tailor.

Dr. W. T. FREEMAN exhibited a case for diagnosis. The patient was a female, aged 50 years; she presented an oval patch on the lower third and inner side of the right leg. The measurements were $5\frac{1}{2}$ in. by 3 in., and it was raised about $\frac{1}{8}$ in. above skin level; the

margin was sharply defined. It was made up of flattened tubercles dovetailed together in pavement fashion.

The patch began at the age of thirty-five as an itching spot about the size of a bean. On either side, corresponding to Scarpa's triangle of the thigh, there was an infiltrated plaque, flattened, but slightly raised, and showing no tuberculated arrangement. Both the patch on the right leg and the patches on the thighs itched violently. There were also considerable itching and infiltration of the skin of the vulva.

There was very little scaling and no scarring anywhere. The mucous membrane of the mouth was healthy, and there was no history of any previous generalised skin-eruption. The urine was healthy.

The itching of the patches had been very materially relieved by an application of equal parts of rectified spirit, glycerine, and acetate of lead, and Liq. carbonis detergens.

It was suggested that X-rays would clear up the lower patch, and the treatment will be tried.

Dr. Freeman undertook to have a drawing made of the tuberculated patch.

Dr. J. M. H. MACLEOD showed a case of *Lichen planus* primarily affecting the mucous membrane of the mouth. The patient was a robust-looking woman, aged 44 years, who had presented herself at Charing Cross Hospital two months before, suffering from white patches on the tongue. On examination the tongue presented numerous irregular white patches, varying in size from that of a pin's head to a threepenny-piece, and more or less symmetrically distributed on each side of the median raphe. On the inside of the lips there were numerous small, yellowish-white specks. On the mucosa of the cheeks small, white patches and branching streaks were observed. The teeth were fairly good, and their edges were not rough, so that the condition of the buccal mucosa did not seem to be due to them. The affection of the mouth had been noted by the patient about two months before she came to the hospital, and its incidence was synchronous with certain domestic worries and the commencement of the climacteric period. A provisional diagnosis of *Lichen planus* of the mouth was made on her first visit to the hospital, but no corroborative evidence of skin-lesions was then detected. A fortnight later the patient again presented herself at the hospital,

and on that occasion an eruption of *Lichen planus* was observed on the flexor aspects of the forearms, on the legs, and around the waist.

Dr. SEQUEIRA showed—(1) a *case for diagnosis*. The patient, a man aged 52 years, had been for twenty-three years an engine-driver, and recently a ganger at the docks. His father had died from consumption, his mother from “cholera.” One brother and two step-sisters also had died from consumption, and a brother, aged 53 years, was suffering from that disease. The patient was married, and had twelve children living and in good health. Six children had died in infancy and early childhood. There was no history or evidence of syphilis. Until eighteen months ago the patient had enjoyed good health. He then had begun to complain of intense itching of the skin of the arms, legs, and lower abdomen. Twelve months ago he had noticed that the skin of these parts had become “red and rough.” The itching had increased in severity, especially at the flexures and the scrotum. Four months ago he had noticed lumps in the groins upon both sides. The itching had of late been almost unbearable. He had been unable to sleep, and had lost flesh.

When exhibited the following conditions were noted: The skin of the arms, legs, lower abdomen, and back was covered with small red papules, discrete upon the upper part of the arms and abdomen but confluent over the lower parts of the arms, wrists, thighs, and ankles. The colour of the eruption was dark red, and in parts there was slight scaling. Upon the lower extremities the confluent papules were flat, but in the upper parts the flat character was less marked; there were no acuminate lesions. The skin of both palms and soles was thick, brown, and scaly. The eruption throughout had been of a dry character. In each groin there was a chain of enlarged hard glands along the internal saphena vein and along Ponpart's ligament. The largest glands were as big as small walnuts. In both axillæ there were small, hard glands. The gland-tumours were discrete, movable, and attached to the skin. They were not tender.

The epigastric veins were enlarged and prominent, but no abdominal tumour could be felt. The liver was not enlarged, and the spleen could not be palpated. There were no abnormal physical signs in the thorax. The optic fundi were normal. The urine contained a slight trace of albumen on admission to the hospital, but that had

cleared up since the patient had been in bed. No casts were found. The blood was examined, and the following condition observed: The red cells were slightly below normal in number. Dr. Grünbaum reported that the red corpuscles were well formed, but variable in size. No nucleated cells were seen. The white cells were slightly increased in number. The percentage count gave the following results: Polynuclear corpuscles 59 per cent., lymphocytes 15 per cent., hyaline 4.5 per cent., eosinophile 21.5 per cent. The slight leucocytosis was due to the increase in the eosinophile cells.

The exhibitor showed the case with a view to getting an expression of opinion as to whether the condition of the skin was due to lymphadenoma or the gland condition the result of the eruption and incessant scratching. The fact that erythrodermia and itching of the skin preceded the glandular enlargement in Hodgkin's disease was well known. No decided opinion was given by members present. Mr. Eve, who has seen the patient since the meeting, was of opinion that the gland-enlargement was the result of irritation. He thought that the absence of gland-tumours from the cervical region was against Hodgkin's disease.

(2) A case of *Paget's disease of the penis*. The patient, a commercial traveller, aged 77 years, had noticed two years ago a painful red patch at the junction of the prepuce and glans. There was a slight discharge from the area. Various local applications were used but without improvement, and in April last Dr. Miller performed circumcision. The local applications were still continued, but the area steadily increased. He was then sent to Dr. Sequeira with a view to a trial of the X-rays. When shown at the meeting there was an oval, red, raw-looking area in the sulcus behind the glans penis. The surface was bright red, granular, and moist. It had the characters of the malignant papillitis of the nipple described by Paget. There was no infiltration, and the lymphatic glands were unaffected.

THE DERMATOLOGICAL SOCIETY OF GREAT BRITAIN AND IRELAND.

A MEETING of this Society was held on Wednesday, October 25th, 1905, at 4.30 p.m., Dr. H. WALDO in the chair.

The following cases were exhibited :

Dr. ALFRED EDDOWES showed—(1) a young man who was the subject of well-marked attacks of *acute circumscribed œdema* (*Quincke's disease*). During the few months in which the patient had been under observation he had, as requested, kept a diary of the attacks. On reference to these memoranda there appeared a striking tendency for the attacks to occur on Monday morning, and during one month they only took place on this day of the week. The exhibitor remarked upon the close connection between diet and diseases belonging to the urticarial class. He explained "Monday eruptions" in these cases as being generally due to the different arrangement of meals and the richer kind of food indulged in on Sunday in this country. It was a common practice to have a later breakfast and for the Sunday meals to be fuller and nearer together than those of the week-day. When in general practice many years ago, he met with cases which he was in the habit of terming "Monday morning headache." It was surprising to find how much was effected occasionally in serious illnesses by a little change in diet. With regard to the treatment of the present case, it was intended to try the effect of Dover's powder, which was a remedy likely to prove useful, for several reasons. He had not yet had time to properly test it in this case, as he had only received the suggestion a few days ago from Dr. Johnson, of Mombasa, who was now on a visit to London.

(2) He also showed (through the courtesy of Mr. Dimock Saunders, of Salisbury) photographs of the patient with confluent lupus affecting the scalp, face, and the upper part of the neck, shown at a previous meeting of the Society. At that time the patient was suffering great pain, and there was extensive dermatitis, which was thought to be in part due to X-ray treatment. His condition had now greatly improved and he was free from pain, the skin having completely cicatrised.

Mr. T. J. P. HARTIGAN exhibited—(1) three cases of *angio-keratoma*. Two of these were sisters, aged 5 and 4 years, and the disease began in each when they were two years old. According to the mother, “a small red spot first appeared and extended, and then it became raised and hard.” The lesions were about the size of a split-pea, and situated on the dorsal aspects of the proximal phalanx of the ring finger in the older child and the middle finger in the younger. Except for a minute spot in the centre, the blood could be expressed from them. The older child had a telangiectatic spot the size of a pin’s head on the nose, which the mother said was the way “they began,” and the younger had had a *naevus* surgically removed from the vulva. The family was made up of one more child, aged 3 years, and this also had had a *naevus* on the cheek. The consins and aunty of these children had *naevi*, which had been cured by pricking with a needle or by cauterisation. They did not suffer from chilblains.

The third case was that of a female, aged 28 years, who suffered from cold hands. It was susceptible of other constructions, but for the purpose of comparison the exhibitor showed the case with the foregoing. The condition had lasted for two and a half years, and was worse in summer. The spots began on the left thumb and had extended to the digits of both hands, several being now affected. Many of the lesions were like chilblains, but some that bore a resemblance to the preceding cases were not now so marked as when she was seen a few days ago. They were then small, reddish, hard papules that disappeared without breaking or scarring. The feet were normal.

Dr. WILFRID WARDE remarked upon the alliance which seemed to exist between this affection and *Lupus erythematosus*. The lesions were undoubtedly of a chronic inflammatory nature. He referred to the observation of Unna with regard to the presence of the minute hæmorrhagic centre invariably found in a chilblain.

(2) *A case for diagnosis*.—The patient, a boy, aged 9 years, attended the Blackfriars Hospital for cheiro-pompholyx. After he had been taking half a grain of quinine twice daily for three days, a generalised patchy erythema broke out. The quinine was stopped, but the redness persisted for the past six weeks and the eruption had recently become scaly. There was some *seborrhœa capitis*. There was no

doubt that the eruption at first was due to the quinine, the condition now perhaps being a superadded eczema.

The members of the Society agreed with the view of the exhibitor regarding the nature of the case.

(3) An unmarried female, aged 39 years, who, when he first saw her, a month ago, had discrete urticarial lesions on her right forearm, some of which were capped with a vesicle. There was no evidence of scabies, and she had had similar spots at different times all over her body. An interval of four months might exist between the successive outbreaks, and the disease had lasted five years. No particular article of diet seemed responsible, and her heart and functions were healthy.

On the back there were slight scarring and pigmentation, and now there was little else to be seen. Factitious urticaria was well marked. If the case were not one of Dermatitis herpetiformis—and he did not regard it as such—the only other alternative was a vesicating urticaria.

The question of Dermatitis herpetiformis was discussed by the members present, but the general opinion was that the case was one of papular urticaria accompanied by vesication.

Mr. SPENCER HURLBUTT showed two cases from Dr. Graham Little's clinic at St. Mary's Hospital.

(1) A case of *tertiary syphilis and vitiligo*. E. R—, a married woman, aged 39 years, attended the Out-Patients' Department three years ago with a tubercular syphilide on the forearm and forehead, remaining under treatment for twenty-three months. She discontinued taking medicine in August, 1904. In May of this year a tertiary infiltration, affecting the skin about the tip of the nose, appeared, which was now disappearing under the influence of iodide of potassium. The case was mainly of interest owing to a co-existing vitiligo which was first noticed about Christmas, 1904, and which could now be seen on the back of both forearms and the back of the neck as rounded, irregular, white patches, the margins of which showed an increase of pigmentation. There were no subjective symptoms or disturbances of sensation.

Mr. GEORGE PERNET pointed out that many writers connected the two conditions leucoderma (vitiligo) and syphilis. He had seen vitiligo in syphilitics and also in patients in whom syphilis was absent. In Mr. Hurlbutt's case the vitiligo was undoubted, although about the neck it was much like that which was

observed in syphilis, and probably a coincidence. Pautrier, of Paris, had written an interesting paper, entitled "Les Rapports de la Syphilis et du Vitiligo."*

(2) A case of *Lichen planus* in a man, aged 20 years.—The patient stated that the eruption first appeared a month ago on the left side of the trunk and spread across the abdomen and back, finally appearing on the legs and arms. He was a healthy labouring man, not of a nervous disposition, and he gave no history of shock, worry, injury, or any other likely cause for the eruption, which consisted of typical, flat, shiny papules, almost universally distributed upon the body and limbs. On the extensor surface of the forearms there was a considerable thickening, with some serous oozing with resulting scabs, due to an adventitious dermatitis, and a similar condition prevailed upon the scrotum. The mucous membrane of the interior of the mouth was also affected.

Dr. T. MANNERS-SMITH exhibited a man, aged 58 years, in whom a small scabby patch had appeared upon the dorsum of the right hand two years ago, and had gradually increased in size. There was no history of syphilis or tubercle, and there were no other lesions. He was a farmer, and he stated that after killing a diseased pig the patch seemed to grow more quickly. There were no oozing points visible, but the case had not long been under observation.

Various members discussed the case, which excited considerable interest. The general opinion was that the lesion was of too superficial a character for syphilis, while its similarity to blastomycosis and also to verruca necrogenica was at the same time remarked upon. A section of the growth and a culture from its surface would probably reveal its real nature.

Mr. GEORGE PERNET brought forward the following cases: (1) A private patient with *koilonychia*, or spoon-nails, shown at the April meeting of the Society.† She was exhibited again in order to demonstrate the great improvement in the nails which had followed the administration of arsenic internally and the local application of a salicylic acid ointment. The nails of the index and middle fingers on both sides, which were the ones mainly affected by the spooning, were now practically normal, of good colour and texture. The keratosis of the nail-bed observed in one had quite disappeared. The ring-finger on the right side showed a very slight tendency to spooning at one distal corner, with a little keratosis.

* 'Rev. Prat. des Mal. Cut. et de. Syph.', Mai, 1904.

† Brit. Journ. Derm., June, 1905, p. 228.

(2) Three cases of *pigmentary syphilide* of the neck: (a) A Jew, aged 24 years, with fair skin and moustache. He had come under observation in July last with the scar of a primary chancre on the pubes, which had been first seen four months previously. With regard to this Mr. Pernet pointed out that he had seen several cases of pubic primary sores among the circumcised Arabs of North Africa, owing to their habit of shaving these parts, the small wounds inflicted by the razor becoming infected by the syphilitic virus. The patient exhibited had, in July last, a raised syphilide (the so-called "urticarial syphilide"), with other secondary symptoms. On August 22nd a pigmentary syphilide was noticed—slight, it is true, but undoubted—about the lower part of the neck.

(b) A man, aged 25 years, who first attended in September for bilateral ulceration of the throat, with the remains of a macular rash about the trunk and an involuting primary chancre of the prepuce, still cartilaginous to the touch, dating from May. He had been under treatment at another hospital. At the present time he showed a slight pigmentary syphilide of the neck.

These two cases were shown on account of the rarity of a pigmentary syphilide of the neck in men. The exhibitor recalled two cases he had seen in Professor Fournier's clinique in which the skin changes were associated with some of the secondary female sexual characteristics. In the two men he had shown to-day this point might apply, to some extent, in the case of the first. The latter patient also presented areas of syphilitic alopecia.

(c) A woman, aged 35 years, who was shown to illustrate the typical pigmentary syphilide of the neck (*collier de Venus*) as it occurs in women.

(3) A German, aged 19 years, with mild *Dermatitis herpetiformis*, which had existed for about ten years.

MR. PERNET also showed a microscopical section from a case of *navi cyst-epitheliomatosi disseminati* (Lymphangioma tuberosum multiplex).

Dr. V. H. RUTHERFORD exhibited—(1) a man, aged 43 years, with a *rodent ulcer* of four years' duration, situated on the left malar evidence, and perforating into the left nostril. Fresh granulation-tissue was apparent after four exposures to the X-rays.

(2) Two children suffering from *ringworm of the scalp*. A portion

of the affected area had received, in each case, one exposure to the X-rays a fortnight ago, according to Sabouraud's method. The deluvium of hair was complete.

The members requested that these cases should be brought up again at the conclusion of the treatment.

Mr. HARTIGAN remarked upon the atrophic condition of the roots of the hairs that could be seen a few days after X-ray treatment, the bulbs being quite conical.

(3) An epileptic girl, of Jewish extraction, aged 15 years, with a multiform, irregular *eruption due to bromide of potassium*. The rash had lasted for upwards of a year, affecting the arms, forehead, and legs, where prominent tubercular masses could be seen.

Dr. T. D. SAVILL showed two cases of *Epidermolysis bullosa*. The first case, which was under the care of Dr. Agnes Savill, was that of a single woman, aged 26 years, a milliner, the youngest of eight children, in whom blisters would form, without any cause, all her life, being worse in summer, and occurring chiefly where friction or slight traumatism were in operation. Three days after birth a bulla appeared on the leg, since when various parts of the body have been affected, with the exception of the hands. Some scars of recent bullæ were visible at the present time in front of the elbows and on the anterior axillary folds. The nails were dystrophic. The bullæ were rarely hæmorrhagic, being usually filled with a clear or slightly cloudy fluid. The subjective symptoms complained of were a slight itching felt when the bullæ were drying up and a pain in those bullæ situated upon the legs.

The case had been treated with the extract of ergot, four grains three times a day, since last August, and the patient stated definitely that she had been much freer since this treatment had been adopted.

The brother of the above, a man, aged 44 years, was also shown. Upon the anterior surface of the right leg was a raw surface, the result of recent repeated blisters. The nails of this patient were also dystrophic. He, likewise, had had the disease all his life.

Dr. STAINER inquired if any member had seen this affection die out altogether with advancing age.

Mr. PERNET stated that he had seen it thus disappear, and he referred to the cases of this disease exhibited by him before the Dermatological Society of London.*

* *Vide Brit. Journ. Derm.*, 1902, vol. xiv, p. 172; and vol. xvi, 1904, p. 225.

Dr. EDWARD STAINER showed a girl, aged 14 years, with a small, painful, pigmented patch, over the outer malleolus of the right ankle, of eighteen months' duration. There was no history of injury, and the lesion was unaccompanied by itching. In the opinion of the exhibitor it was a tubercular affection.

In this view most of the members concurred, though a few thought that the condition was allied to Lichen planus, or that it was a septic infection occurring after some slight injury.

QUARTERLY SURVEY OF DERMATOLOGICAL LITERATURE.

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